MARCH, 1948

Rhode Island
MEDICAL JOURNAL

The 137th Annual Meeting

CHECK THE DATES NOW

MAY 12—13, 1948

THE RHODE ISLAND MEDICAL SOCIETY

THE RHODE ISLAND MEDICAL SOCIETY • HOSPITAL ASSOCIATION OF RHODE ISLAND

Volume XXXI, No. 3

Contents Page 159

The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXI MARCH, 1948 NO. 3

THE POSITION OF THE GENERAL PRACTITIONER TODAY

JAMES M. FAULKNER, M.D.

The Author. *James M. Faulkner, M.D., of Boston. Dean, and Professor of Clinical Medicine, Boston University Medical School.*

WHEN I WAS INVITED to talk to you on this topic tonight I accepted gladly, although fully realizing that I was rushing in where angels fear to tread. It is indeed a subject on which strong opinions are voiced and yet no one can speak with authority. It is perhaps the most pressing problem which faces the medical profession today, and its solution will require all the tact and resourcefulness and submergence of selfish interest which we can bring to bear on it. We cannot afford to evade the issue. To do so would be running the risk of allowing the situation to degenerate into futile jurisdictional strife. It is to be hoped that objective and open-minded discussions such as we are having here tonight may help to clarify the present status of the general practitioner and to point out what can be done to give him a more assured status in the medical economy of the future.

In approaching this subject, I wish to make it clear that I am not going to touch on the subject of rural medicine which is a separate and distinct problem.

In order that you may make due allowance for my own prejudices, I should confess to you at the outset that I have been a specialist in internal medicine ever since I went into practice some twenty years ago and that for the last six months I have given full time to problems of administration and education in a medical school. However, as the son of a general practitioner of the old school who used to take me along on many of his calls in buggy or sleigh, I did get some appreciation of the role of the family doctor in a small town and the respect which he enjoyed not only in the community but also among his professional colleagues.

The status of the general practitioner has changed considerably since those pre-World War I days. The rise of the Specialty Boards to positions of great power and influence has stimulated tremendous interest on the part of young men preparing for practice but at the same time it has produced a feeling of uneasiness in the general practitioner, who up to recently has had no organized group of his own through which to make his voice heard. He has seen appointments to hospital staffs made dependent on board certification. He has seen rank and pay made dependent on board certification in the armed services and in the Veterans Administration. He sees fewer and fewer men going into general practice. He feels that the prestige of the family doctor is slipping and he becomes dispirited if not disgruntled.

If we examine the factors responsible for the change in status of the general practitioner we shall see that they fall naturally into two classes: (1) socio-economic factors common to the whole community, and (2) changing standards of practice set up within the medical profession itself. Let us look at the socio-economic factors which have influenced the practice of medicine.

Improvement in transportation and communication. Without question, the automobile and the improved roads have tremendously widened the area which a practitioner can serve, and at the same time the telephone has made him more accessible. The effect has also been to give patients

continued on next page

* Presented at the joint meeting of the Rhode Island Medical Society and the Providence Medical Association, at Providence, February 2, 1948.

access to more doctors, including specialists, and to more hospitals.

The urbanization of our country to the point where now 60% of the population live in cities, instead of 30% a generation ago, has simply intensified all of the factors above mentioned.

A general increase in the standard of living has made it possible for a larger proportion of the population than formerly to pay specialists fees and hospital expenses, and this shift has been to some extent at the expense of the general practitioner.

Along with urbanization, a higher standard of living and *wider dissemination of health information,* there has been a marked trend toward *more hospitalization.* A conspicuous example of this is in Obstetrics, which has always been one of the main supports if not the backbone of general practice. The hospitalization of obstetrical cases has reached the point in Massachusetts where many large towns do not register a single home delivery in the course of a year and, in Boston at least, the district deliveries by medical students are a thing of the past.

The tendency to increased hospitalization applies to other fields besides Obstetrics and unquestionably this tendency has been further increased by the Blue Cross. The desirability or undesirability of increased hospitalization we are not concerned with now. I simply wish to make the point that in recent years a larger segment of practice has been carried on in the hospital rather than in the home. The importance of this is that hospital practice is more or less regulated, whereas house practice is not. In the hospital the doctor must submit to the rules laid down by the Trustees and Staff, rules which restrict the procedures which members of the staff are permitted to carry out and which regulate new appointments and promotions. In a number of hospitals, specialty board membership has been made a prerequisite for membership on the staff, for certain positions on the staff or for sanction to perform certain operations. This practice has sometimes worked an unfair hardship on well qualified men who had not taken their boards. It has become the subject of bitter criticism and has been officially disapproved by the Advisory Council of Medical Specialties as well as by a number of the constituent specialty boards. As it has worked out, the number of instances where a qualified general practitioner has actually lost his staff membership because of lack of Board certification is probably not large. In many more instances, general practitioners have been told that they could no longer undertake major surgical operations or major obstetrical procedures because they did not possess the proper Board qualifications. In larger hospitals, however, there has been a tendency to restrict new appointments to the staff to Board men. The general shortage of hospital beds and the argument that such a policy automatically protected high standards of practice within the hospital made such regulations attractive alike to Trustees and staff. The effect in those communities has been to deny to young general practitioners who have not yet established their hospital connections any opportunity of doing so. Incidentally, a good many of the harsh words which have been said about the Specialty Boards in this controversy might better have been directed against the hospital authorities. Too often the hospital has used the Boards' requirements as a convenient and outwardly impersonal way of disqualifying men for staff membership or promotion rather than attempting its own evaluation of his qualifications—admittedly a very different job, especially in a small hospital. Without delving into this aspect of the problem any deeper, I think we will agree that on the whole general practitioners have yielded ground to specialists in hospital practice.

So much for the factors which have put the general practitioner where he is today. What is his outlook for the future? Is he going out of existence like the horse and buggy? It seems safe to predict that as long as our system of private medical care exists the family physician will continue to carry the bulk of the practice. Indeed, outside of a completely regimented medical economy with no individual choice of a physician, it is impossible to conceive of medical care without the family physician. Even were we able to eliminate completely that aura of sentiment and affection which is attached to the name of family physician, we would still find that from the purely practical point of view he plays an absolutely essential role in the profession; for he with his intimate knowledge of the family background is in a unique position to evaluate the patient's symptoms in their true perspective. He, better than the specialist, can understand the patient as a social human being rather than as an assortment of organs. Even if, as seems possible, more and more practice is going to be done in groups, there is no reason why the general practitioner might not hold the key position in such groups. All new patients would pass through his hands and would be referred to specialists only if he deemed it necessary. He would be the logical member of such a group to maintain the old doctor-family relationship. Whatever further evolution may take place in the content of general practice there will always be a demand and a need for the family physician. If we accept this statement as true, then the question arises as to whether we should take a positive attitude toward

the problem or whether we should adopt a laissez-faire attitude.

The problem is too immediate and too complex for sidestepping the issue. Affecting as it does the very bone and sinew of the profession, it cannot be allowed to fester.

What is being done to correct the situation? A good deal is being done from many different angles. I shall discuss three different approaches to the problem: (1) the medical schools, (2) the hospitals, and (3) organized medicine.

I have occasionally heard people deplore the fact that medical schools turn out so many specialists, as if a medical school *could* turn out a specialist and as if medical schools had any control over what types of practice its graduates took up. It is true that practically all teaching in medical schools is done by specialists, and it may well be that this exerts an influence on students to become specialists themselves. It is not an easy matter to counteract this influence by bringing medical students in significant numbers into intimate contact with first class general practitioners. The University of Vermont Medical School has done this by assigning fourth year students as clinical clerks in rural hospitals throughout the state under the guidance of certain local practitioners who hold official teaching positions in the School. These students have an unusually good opportunity to observe general practice at first hand, and many of them choose that field on graduation. A number of medical schools, including Tufts and Boston University, have a course in so-called District Medicine in which the students make house calls and get at least a smattering of an idea of the problems of caring for a patient in the home. However, training for general practice must necessarily be largely a post-graduate affair.

The medical schools could further the training of general practitioners by assisting hospitals to develop intern and resident programs specifically oriented toward general practice. The University of Colorado has recently organized such a program with the help of the Kellogg Foundation. The Tufts College Medical School, The University of Rochester Medical School, and others are actively engaged in trying to build up good post-graduate training programs in smaller hospitals for the benefit of future general practitioners. Much remains to be done along this line in New England. There is too much of a gap between the first class rotating internship, such as is offered by the Rhode Island and the Hartford Hospitals, and the second class internships. Too many first class hospitals have second class internships and as a result are having difficulty filling their quota of interns. In my opinion, and I am sure that my opinion is shared by most students who are seeking internships, the one year rotating iternship is inadequate preparation for general practice. Every hospital which is large enough to provide adequate teaching material should establish two year internships. The first year could be on a rotating basis and the second year could be devoted largely or exclusively to medicine or surgery and of such a calibre that it would receive Board approval as an assistant residency if the incumbent wished to proceed along the road to Board certification in Internal Medicine or in Surgery. The important point is that when the man is accepted as an intern it would be understood that he would be kept on for a second year if his services were satisfactory. This second year of training would go far in eliminating the too great discrepancy which now exists between the training of the general practitioner and the specialist and would, in my opinion, add greatly to the stature of the young general practitioner. Of course, an internship as such has very limited value unless it is conducted as a well organized, well integrated teaching program preferably under the direction of one member of the staff who is charged with this responsibility. In the course of many interviews with students seeking advice on internships I have found that they are apt to judge a hospital more on the basis of its teaching program than on any other factor. Competition for interns will, I believe, force hospitals to develop more adequate teaching programs than they have in the past. In a larger measure than ever before, the training of our future general practitioners is becoming a hospital responsibility. The medical schools might logically be asked to assist in the development of such programs but they are not in a position to initiate them.

On the burning issue of staff appointments, some hospitals have rescinded previous rules requiring Board certification. An important new development has been the establishment of general practice divisions in the staffs of a number of large hospitals. The general practice service, like the surgical service or the medical service, has its own chief and holds its own Staff meetings. This arrangement gives the general practitioner the opportunity to care for his patients in a hospital within the limits of his qualifications together with all the educational advantages and prestige factors which go with a hospital staff appointment.

In June, 1945, the American Medical Association gave recognition to the special problem of the general practitioner by organizing the Section on General Practice. Some physicians have thought that this was not going far enough. Repeatedly over the years resolutions have been introduced into the House of Delegates calling for the creation of a specialty board in general practice. This idea

continued on next page

has not met with general favor. If such a board were to have any meaning at all, it would have to set high standards. High standards in such a broad field as general practice might indeed be harder to meet than the existing standards of some of the specialty boards. The chances are that only a small fraction, perhaps 10%, of the general practitioners would have the time, energy, and ability to meet the requirements. This would leave the vast majority of the general practitioners in a far unhappier position than they are in now.

In June, 1947, the American Academy of General Practice was organized at Atlantic City. Its official objectives are as follows:—

"Objectives:—

(1) To promote and maintain high standards of the general practice of medicine and surgery.

(2) To encourage and assist in providing post-graduate study for general practitioners in medicine and surgery and to encourage and assist practicing physicians and surgeons to participate in such training.

(3) To encourage and assist young men and women to prepare, qualify, and establish themselves in general practice.

(4) To protect the right of the general practitioner to engage in medical or surgical procedures for which he is qualified by training or experience.

(5) To advance medical science and private and public health.

To be eligible for membership the physician must be engaged in General Practice. He must be duly licensed in the state in which he practices, and must be of high moral and professional character. He must have had at least one year of rotating internship at an approved hospital, or the equivalent in post-graduate training. He must have been in General Practice for at least three years. He must have shown interest in continuing his medical advancement by engaging in Post-Graduate educational activities."

To continue as a member it is necessary to complete 150 hours of Post-Graduate work in each three year period. In fulfilling these requirements, it is expected one-third of this time may be spent at staff meetings, one-third at conventions, and one-third at Post-Graduate courses. The emphasis on continued post-graduate education is laudable and it looks now as if the general practitioner were going to have a strong national organization to look out for his interests.

The kinship between the general practitioner and the internist is a very close one. Their field is very much the same. It is usually one or the other of these two who sees the patient first and who has the responsibility for making the preliminary diagnoses. If one projects present trends into the future, one would predict that in another generation the family doctor will be doing little or no obstetrics and no major surgery but will be confining his attention almost entirely to internal medicine and pediatrics. This close affinity has been recognized by the American Board of Internal Medicine which has liberalized the requirements for certification for that Board by allowing credit for years spent in practice to be substituted for residency requirements in qualifying for the examination. Four years of practice in internal medicine are given credit equivalent to one year's residency in internal medicine. The basic requirements for the American Board included one year of internship, three years of residency or fellowship in internal medicine, and two years of practice. Under the new provisions, a man may take only one year's residency and substitute eight years of practice for the remaining two years of residency requirement, or he may after twelve years' practice of internal medicine qualify for the Board examination without any more formal post-graduate training than an approved internship. This means that a man who for personal or economic reasons may not be able to spend three years in residency training still has an opportunity to obtain Board certification later on if he can pass the examination.

In closing, may I summarize my remarks in a few words.

(1) The relative position of the general practitioner as a group within the medical profession has suffered as a result of several factors, chief among which are: (a) socio-economic factors which are to a large extent beyond our control; (b) changing standards of medical practice which have worked to the advantage of the specialists; and (c) the rise of the specialty boards with their well organized and vocal national groups to which the general practitioners have had no counterpart.

(2) Efforts are being made to restore a proper balance between the general practitioner and the specialist by: (a) The development of internship and residency programs specifically organized to train men for general practice. (b) The establishment of a Section on General Practice in the American Medical Association. (c) The liberalization of the requirements for certification by the American Board of Internal Medicine which permits a practitioner to substitute a certain number of years of practice in internal medicine for the hitherto rigid residency requirements. (d) The formal disapproval by the specialty Boards of board certification as a requirement for hospital staff appointments. (e) The establishment of general practice sections in hospitals. (f) The organization of the American Academy of General Practice.

continued on page 182

LEAVES OFF THE TREE*

REGINALD FITZ, M.D.

The Author. *Reginald Fitz, M.D., of Boston, Mass. Member, Council on Medical Education and Hospitals, American Medical Association; Past President, Massachusetts Medical Society; Lecturer, History of Medicine, Harvard Medical School; Charles V. Chapin Orator, 1944.*

THE AUTOCRAT, as everyone knows, was a very wise old gentleman. He made a profound observation at the breakfast table one morning when he said that in New England we are apt to go for the man — and he might have added, for the Medical Society — that inherits family traditions and the cumulative humanities of at least four or five generations and that has a gallery of family portraits to be proud of.

Today, the Providence Medical Association has passed the century mark. It has managed to grow younger and more vigorous year by year so that it must have discovered the secret of perpetual youth. How has it survived so gaily more than a thousand and one nights of strenuous programs?

Sixteen years ago, in his President's Address, Dr. John E. Donley was the most recent member, until he and Dr. Chase and Dr. Hammond re-told it, to tell the story of the Association's early days: how on January 31st, 1848, at the office of Dr. H. W. Rivers, the Association was born; how Dr. S. Augustus Arnold was elected the first President, Dr. J. W. C. Ely the first Secretary, Dr. Lewis W. Clifford the first Treasurer; and how its first Standing Committee included, among others, Dr. Henry P. Pratt.

I mention the names of Clifford, Ely, and Pratt with especial pride because they were graduates of the Harvard Medical School and therefore, by adoption, if you like, Proper Bostonians. They proved an interesting triumvirate. Clifford was the senior member, an older man recommended for admission to the School by no less a personage than Dr. Usher Parsons. He was thirty-nine years old when he received his medical degree in 1845; perhaps his age and his general gravity of deportment made him appear the most suitable candidate to become the original custodian of the Association's purse. Not much is known of him, unfortunately, beyond that he served honorably and that no eyebrows were raised over his accounting system.

Dr. Ely and Dr. Pratt as students were more typical of the ordinary undergraduate of today; mannerly boys who were popular among their fellows and soon able to attract the favorable attention of their professors. Dr. Ely graduated in 1846 and Dr. Pratt in 1847.

While they lived in Boston these three Rhode Islanders, I presume, occupied lodgings close to-

continued on next page

* Presented before the Providence Medical Association at its Centennial Celebration, at Providence, January 31, 1948.

Title pages of the first two published histories of the Association. The Atlantic Medical Weekly went out of existence in 1899. The RHODE ISLAND MEDICAL JOURNAL began in 1917.

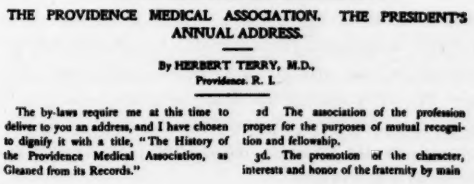
THE RHODE ISLAND MEDICAL JOURNAL
The Official Organ of the Rhode Island Medical Society
Issued Monthly under the direction of the Publication Committee
VOLUME XV NUMBER 2 | Whole No. 269 PROVIDENCE, R. I., FEBRUARY, 1932 PER YEAR $2.00 SINGLE COPY 25 CENTS

ORIGINAL ARTICLES

THE PRESIDENT'S ADDRESS*
THE BEGINNINGS OF THE PROVIDENCE MEDICAL ASSOCIATION
By JOHN E. DONLEY, M.D.
222 BROADWAY, PROVIDENCE, R. I.

Our forefathers who rule us so gently yet imperiously from their urns, laid upon its retiring President the duty of delivering before this Association at its Annual Meeting, an address having special reference to the work and needs of the by a label on the inside of the cover, by Charles Burnett, Jr., Bookseller and Stationer, at No. 3 Westminster Street, Providence. In it, as even today by our own Secretary, so tenacious are we of tradition in conservative Providence, the records of meetings are written in longhand. Of some Secretaries the handwriting is legible easily, a symbol of a careful hand marching in unison with the mind; of others, the writing is difficult to decipher, indicating perhaps, a pen unequal to the rapidity of the thoughts it would express, or possibly, a little careless of Secretarial niceties.

Turning the pages of our family record, we learn that at a meeting of the physicians of Providence, held at the office of Dr. H. W Rivers, on



THE
Atlantic Medical Weekly
A Journal of Reform and Progress in the Medical Sciences.
$2.00 Per Year, in Advance. Single Copies, Five Cents.
Vol. IX. SATURDAY, MARCH 19, 1898. No. 12.

ORIGINAL ARTICLES.

THE PROVIDENCE MEDICAL ASSOCIATION. THE PRESIDENT'S ANNUAL ADDRESS.

By HERBERT TERRY, M.D.,
Providence, R. I.

The by-laws require me at this time to deliver to you an address, and I have chosen to dignify it with a title, "The History of the Providence Medical Association, as Gleaned from its Records."

2d The association of the profession proper for the purposes of mutual recognition and fellowship.

3d. The promotion of the character, interests and honor of the fraternity by main

gether on Beacon Hill so that in winter they could slide down comfortably to their clinics at the Massachusetts General Hospital and there become exposed to the wisdom of such teachers as Dr. John C. Warren in Surgery, Dr. Walter Channing in Obstetrics, and the notorious Dr. Webster in Chemistry. And Pratt had additional initiative — or money — with which to enroll for a spring term in the newfangled Tremont Street Medical School and to encounter the more modern and radical teachings of Dr. Oliver Wendell Holmes, Dr. Humphreys Storer, and young Dr. Henry J. Bigelow.

The course at Harvard consisted almost entirely in lectures with the single mitigating circumstance that in Medicine the students actually handled patients and, according to the Catalogue, thus were given opportunity of learning the new method of "exploration of the body for the PHYSICAL SIGNS of disease by *palpation, auscultation* and *percussion*". Otherwise they spent their time as listeners, absorbing through their ears, as best they could, the whole Science of Medicine.

At the Tremont Street School, on the other hand, the course was livelier and less theoretical. Dr. Storer supervised young Pratt in delivering a number of babies on the District, Dr. Holmes introduced him to the mysteries of the microscope, and Dr. Bigelow made him feel at home at the bedside on surgical ward rounds at the Hospital.

Medical student life, as it always is, was fairly strenuous; almost the only social outlet, except for an occasional toddy, was to be found in meetings of the Boylston Medical Society. The story goes that a worthy gentleman by the name of Ward Nicholas Boylston inherited a considerable fortune from an uncle who had been successful in the China trade and a fair share of this he finally bequeathed to Harvard College. One of his forbears was Zabdiel Boylston, the inoculator, and from him Ward Nicholas claimed an inherited interest in medicine.

The Boylston Medical Society, named in honor of Mr. Boylston, was more than thirty years old and a thriving affair when Clifford, Ely, and Pratt came along; both Clifford and Pratt became members.

At each meeting an original paper was presented; there was general discussion; and finally, there were reports of cases or reports on other matters connected with Medical Science. It was a juvenile performance but a form of initiation into medical society procedure and, moreover, the meetings were pleasant, occasionally developing arguments which proved both heated and entertaining. At one meeting, for instance, the paper to be heard was entitled, "Does the moderate use of Tobacco in its various forms tend to injure the health of the system?"

One must remember that the Quaker influence of Rhode Island was still perceptible in Boston and that many parents liked to quote to their sons, when they seemed to be smoking too much, a paragraph from Dr. Benjamin Waterhouse's well known lecture on The Evils of Tobacco:

> The practice of smoking is productive of indolence, and tends to confirm the lazy in their laziness. Instead of exercising in the open air, as formerly, you sit down before large fires and smoke tobacco. This hot fumigation opens the pores of the head, throat, neck, and chest; and you pass out in a reeking sweat into a damp, cold atmosphere; the patulent pores are suddenly closed; hence arise disorders of the head, throat, and lungs. These causes, cooperating with those already mentioned, produce those hectical symptoms and consumptive complaints, that have been multiplying among you to an alarming degree; for this nasty custom includes the destructive effects of indolence, and the pernicious effect of the too frequent use of vinous and ardent spirits; agents, destructive to full grown men; but which act with redoubled force on the more susceptible frames of young gentlemen in the spring of life.

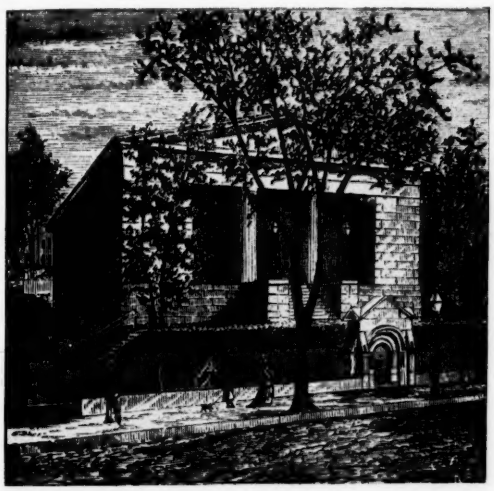
Dr. Waterhouse must have turned in his grave that night as the members of the Boylston Medical Society voted vociferously in favor of the harmlessness of the weed that he so earnestly claimed was an invention of the Devil. No doubt he would have regarded the conduct of the Boylston Medical Society as a further manifestation of Harvard decadence.

There were two more mature medical societies that had considerable influence at the time: the Boston Medical Association and the Boston Society for Medical Improvement. The former did little else than act as Medical Police, establishing a Code of Ethics and a Fee Table. The latter was more active, founded to "cultivate the confidence and good feeling between members of the profession, and to elicit and impart information upon the different branches of medical science". This was the organization before which members of the Harvard and Tremont faculties read their most important papers.

While neither Dr. Clifford, Dr. Ely nor Dr. Pratt belonged to the Boston Medical Association nor to the Society for Medical Improvement, yet probably they knew of their existence and something of their organization. At least it seems a curious coincidence that the Providence Medical Association, with these three Bostonians among the Founders, first assumed Police Powers and established a Fee Table very similar to that of the Boston Association; and that presently when, as Dr. Donley said, the Providence group turned its attention to matters medical, a type of program was adopted that was closely parallel to the one used by the Boston Society for Medical Improvement. From this evidence, tenuous as it is, it is possible, as I like to believe, that these three prod-

ucts of Harvard added an enduring tinge of Crimson to the Association's background colored otherwise so deeply Brown; this, perhaps, may be one reason why Bostonians feel at home at meetings of the Providence Medical Association and have always regarded an invitation to attend any of them as a particularly delicate compliment.

The Association soon established the tradition of progressiveness. After having determined to meet in the Franklin Society's rooms, one of the obvious needs was that of keeping abreast of the times through means other than conversation. Thus, at the December meeting in 1848, Dr. C. W. Parsons suggested that a medical library be formed by subscription, the books and periodicals so accumulated being deposited in the Athenaeum or some other suitable place. The Rhode Island Medical Library grew from this beginning.



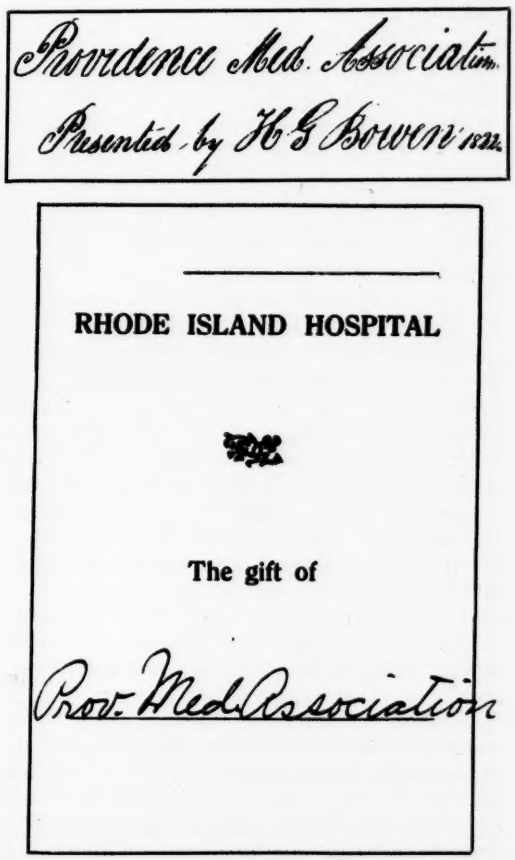
The Athenaeum. During 1848 the Association met in the rooms of the Franklin Society in the basement of this building and later in their rooms on North Main Street. In 1905, because it needed more space, the Association moved to Rhode Island Hall at Brown University and in 1912 to the Rhode Island Medical Society Library.

Periodicals were subscribed to and a few books were purchased until in 1868 the collection occupied so much space that it was transferred to the Rhode Island Hospital for safe keeping and a new and more active library of current literature was again started. This likewise grew rapidly so that in 1876 preliminary conferences were held to establish an adequate medical library for the use of all the doctors of Rhode Island, and in 1880 the second collection of the Providence Association was turned over to the Rhode Island Medical Society.

This collection, like its predecessors, grew rapidly and within ten years the matter of its housing once again presented serious difficulties; the upshot was that funds were gradually obtained for a permanent home and in October, 1912, the present library building was opened.

In the field of medicine the tradition of progressiveness was equally notable. Every useful discovery as it came along was discussed: in the early days, obstetrical problems and those arising from the infectious diseases that visited Providence received most attention. Yet the advantages of ether as an anesthetic agent were described in 1848, and in 1857 a perforated appendix from a fatal case of appendicitis was exhibited. When the time came to establish hospitals and a Board of Health, a purer water supply and better roads, the Association took the lead in their development. As medical novelties cropped up they received the Association's attention: oleomargarine as a substitute for butter in 1876; the telephone in 1883;

continued on next page

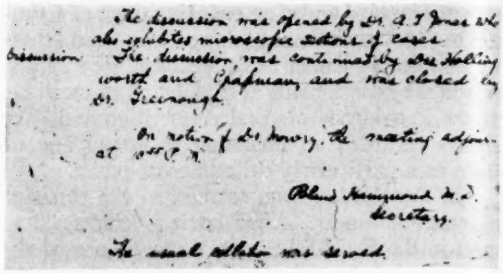


Two early book-plates used for marking the Association's books. Mr. H. G. Bowen was Professor of Natural History in Brown University from 1824-1828 and Librarian from 1828-1840. The exact significance of the figure "1822" is uncertain. From 1868 until 1880 the library was housed in the Rhode Island Hospital. The book-plates are reproduced by courtesy of Dr. Philip Batchelder.

asepsis and the importance of bacteriology in 1891; the x-ray in 1896; tuberculosis control in 1900; the therapeutic use of radium in 1921; and so on down to today through electrocardiography, insulin, liver extract, the sulpha drugs and penicillin, and even to the development of insurance plans against the cost of medical care. Indeed, the minutes of the Association give a graphic account of medical progress during the space of a century, each new diagnostic or therapeutic weapon being described carefully and its advantages or faults being debated fairly and honestly.

A spirit of good fellowship and friendliness among members was another tradition to be cherished from the very beginning. When the Association was small, the President was in the habit of giving an Annual Dinner but this custom passed into desuetude seventy years ago when the task of entertaining more or less of eighty dry and hungry gentlemen seemed too heavy for any one person to bear. In 1879, a resolution was adopted by which a committee was appointed to determine the feasibility of introducing a social element into the Association and the result was the provision of a collation at each meeting forever afterwards, the funds for its cost being drawn from the Treasury. Many Presidents have commented on the wisdom of this procedure; food after a medical meeting undoubtedly promotes friendliness and tends to soothe ruffled feelings.

As the Association became securely established, means for maintaining a printed record of its proceedings were developed. At first, notices of meetings and accounts of what happened at them from time to time appeared in the Providence Journal. After nearly thirty years the Association voted that henceforward no such publicity was proper, and the next vehicle of publication was a periodical known as the Rhode Island Science Monthly which soon turned into the Atlantic Medical Weekly. Neither of these journals proved an entirely satisfactory means of reporting the affairs of the Association though scattered through them can be found a good many of the Association's papers. In 1899, the Providence Medical Journal came into existence, published quarterly by the Association and reporting regularly not only the minutes of the meetings but also many of the papers which were delivered. In 1916, it fell into financial difficulties and sold its rights to the Rhode Island Medical Society. THE RHODE ISLAND MEDICAL JOURNAL which has been published each month since January, 1917, is thus the child of the Association and has grown into a very satisfactory adult under its parent's care. It continues to print the minutes of the meetings and a fair share of the original contributions. A microfilm of the early records of the Association is now available so that at last the history of the Association is well documented in several ways and in accessible form.



A bit of the microfilm. The film makes the Association's early records readily available.

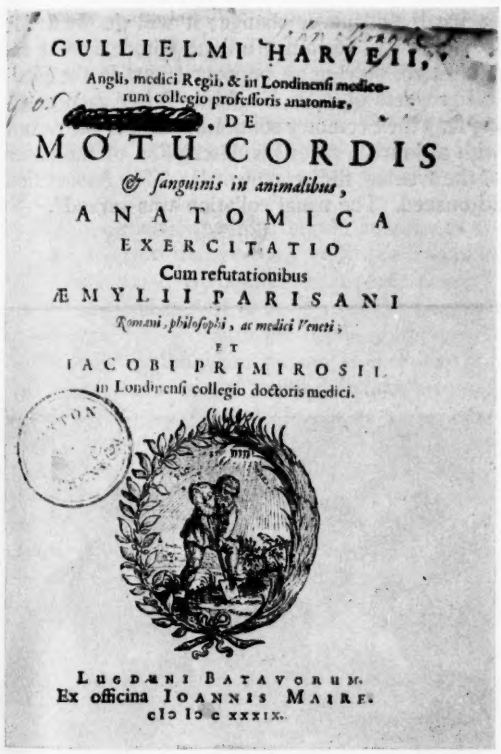
The two pillars of progressiveness and friendliness make a sound foundation on which to build success in any medical society. Yet without vigorous and colorful personalities by which to make the superstructure warm-hearted and enduring, the potential value of such a foundation would be wasted. The essential humanities of the Association which have accomplished this are difficult to describe. They are complex, wholly charming, and distinctive. Perhaps the best way to appreciate them is to turn the clock back and attend a few of the earlier meetings in order to see for oneself how they set the pace for the future.

The Squantum Club. "Composed of Rhode Island gentlemen, it is an association for culture and recreation. It owns a club house at Squantum, a rocky promontory about opposite Field's Point". It originated in 1870 with a number of Rhode Islanders who enjoyed an old-fashioned clambake. The Association dined here on Tuesday, July 14, 1874. A generous Clam Bake and mill punch a-la-Gladding were among the delicacies served.

I wish that I could have gone to the meeting on July 14th, 1874, when Dr. C. T. Gardner arranged an invitation for the members to assemble at the Squantum Club House on the Narragansett Bay. At four o'clock in the afternoon the Association filled the dining room and a generous Rhode Island Clam Bake was presented, embellished, no doubt, with rum punch, speeches, toasts and stories, and lasting until late in the evening. That was one of those rare Rhode Island nights, I suspect, when,

as Dr. Holmes might have put it, the amiable indiscretions of nine months ago were largely overlooked. How the population of Providence became safely increased that evening remains a mystery.

I know that I should have enjoyed the September meeting in 1877 when Dr. George Brug displayed a copy of Harvey's description of the Circulation of the Blood, printed in Latin and published in 1639. I should like to have met him and seen his book and compared it with Dr. James Jackson's copy of a 1639 Leyden imprint and now living in the Harvard Medical School. Are the books identical twins? What are the stories connected with their purchase? What has happened to Dr. Brug's copy?


GVLIELMI HARVEII,
Angli, medici Regii, & in Londinensi medicorum collegio professoris anatomiæ,
DE
MOTV CORDIS
& sanguinis in animalibus,
ANATOMICA
EXERCITATIO
Cum refutationibus
ÆMYLII PARISANI
Romani, philosophi, ac medici Veneti,
ET
IACOBI PRIMIROSII
in Londinensi collegio doctoris medici.
LVGDANI BATAVORVM.
Ex officina IOANNIS MAIRE.
cIↃ IↃ c xxxix.

Title page of Dr. James Jackson's copy of the 1639 imprint of Harvey's "De Motu Cordis". Dr. George Brug exhibited a copy of this book at a meeting of the Association in 1877. In 1913 only three copies were known to be listed in libraries of this country.

I wish I could have been present at the December meeting in 1886 when Dr. G. L. Collins persuaded the Anatomical Wonder to perform, a gentleman calling himself King George and claiming that he was three hundred and seventeen years old. He said that he had two hearts the sound of which could be heard either to the right or the left of the sternum and no diaphragm. As many of the members testified, he was able to stop the arterial circulation at will so that the action of the heart seemed under his immediate control and, also, he could change the shape of his abdomen so that he was able to develop peculiar tumor masses which were difficult to identify; in fact he tried to make people believe that he could move one of his hearts down into his groin. His strength was equally remarkable; he could bend and straighten an iron bar, one inch in diameter and long enough for a cane, by the simple expedient of striking it against his arm. From all accounts he was worth meeting.

Naturally, I should have gone to the June meeting fifty years ago when my old friend, young Halsey DeWolf, fresh from the Medical School of the University of Pennsylvania, was elected a member. He soon was appointed to serve on the Collation Committee, immediately, I expect, and for the endless benefit of posterity, improving the quality as well as the quantity of the food served. His first scientific contribution was in 1900 and on the subject of District Nursing. The children of Providence owe to him much of their good state of nutrition and their pure milk supply; his paper was the first to provoke local interest in two such important phases of public health work.

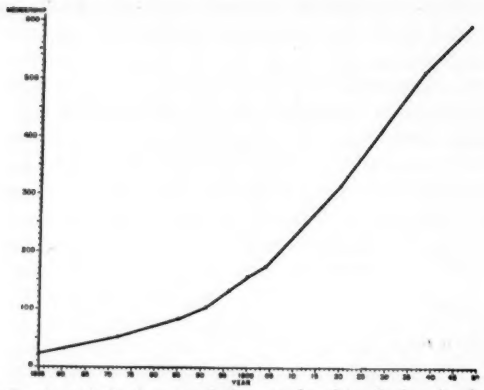
I should also have gone to the November meeting in 1900 when another of my friends and teachers — Dr. Frank T. Fulton — became a member. His maiden paper was not in the field of cardiology but in that of hematology. He spoke about the Anemias in Infancy and Childhood; his first paper dealing with Heart Disease came much later, at the December meeting in 1913, and on the use of Digitalis.

The custom of allowing occasional guests to appear on the program goes back eighty years when Dr. Lemercier of Paris told the Association about the development of the brain, illustrating his remarks with elastic models. Ever since, a number of visitors have been complimented by invitations to attend meetings. I wish I could have heard Dr. C. H. Mayo at the meeting held in his honor in April, 1915. He attracted a large audience, exceeded only by the one which subsequently gathered to hear Dr. Frank Lahey. Dr. Mayo and Dr. Lahey, between them, have the honorable distinction of being the two most popular speakers ever to appear before the Association during its First Hundred Years.

Dr. Mayo talked steadily for an hour. As usual, he was discursive but he emphasized his faith in Rosenow's work on focal infection; he said that no immunity to chronic disease was known, and finally he made the rash statement that stomach ulcer is never cured by medical treatment.

The steady growth of the Association is the last of its most striking characteristics. Not only has

continued on next page



The Association's growth in membership during its first hundred years.

the Association attracted many new and young members year by year who have regularly contributed papers and discussions but also has it passed along from one generation to the next, in the manner New Englanders are proud of, old names as well as old customs: a Parsons was followed by a Parsons, a Collins by a Collins, a Peckham by a Peckham; on the roster now, a Buffum follows a Buffum, a Burgess follows a Burgess, a Cutts follows a Cutts, a Fulton follows a Fulton, a Richardson follows a Richardson. And certainly no other medical society has ever had a Peter Pineo Chase, Secretary for fifteen years, President for one year, and at the moment capable Editor of the RHODE ISLAND MEDICAL JOURNAL in which the Association has such strongly vested interests.

The Providence Medical Association has every right, on its hundredth birthday, to be congratulated; not only on its accomplishments during the last century but also on its traditions, its cumulative humanities, and its family portraits. It can face the future with equanimity. Its character and its ideals will never change; it will go forward; it will always remain a unique Rhode Island organization, playing an important part in the medical progress of New England. After each meeting may the Secretary continue to add to the record with a flourish, after his description of the paper of the evening, the happy words: "The Association adjourned. The usual collation was served".

Dr. Philip Batchelder (right) receives from Dr. Arthur H. Ruggles, President of the Rhode Island Medical Society, the Distinguished Service Award of the Providence Medical Association on the occasion of the Association's Centennial Celebration, January 31, 1948.

A consultation as it might have appeared in 1848 is re-enacted at the Centennial celebration at the Providence Medical Association on January 31, 1948. Dr. G. Edward Crane, the patient, is viewed (left to right) by Dr. J. Merrill Gibson, Dr. Alex M. Burgess, Jr., Dr. John C. Ham, and Dr. Anthony Corvese.

GRADUATE MEDICAL EDUCATION AND HOSPITAL ECONOMICS*

OLIVER G. PRATT, FACHA

The Author. *Oliver G. Pratt,* FACHA, *of Providence. Executive Director, Rhode Island Hospital.*

I AM PLEASED indeed to discuss a subject that is a deep responsibility of every hospital administrator and is so close to the heart of each and every physician. By focusing our attention on this subject "Graduate Medical Education and Hospital Economics" and by discussion, we may clarify our minds and agree on a continuing working basis in the best interest of the people whom we are dedicated to serve.

This presentation will be limited in scope to the unique situation that prevails in Rhode Island — that is as applied to voluntary non-profit non-university hospitals. All must be teaching hospitals and designed to serve all the needs of the people and to consider the whole person as an individual.

A hospital is a special facility, dictated by medical science and experience, to enable the surgeon and the physician to provide patients with the best medical care. It is also the only practical instrument for teaching doctors and training nurses for our communities.

Trustees of our voluntary hospitals are charged with the legal and moral responsibility not only of safeguarding the finances, but also of providing the patients with proper quality of medical care.

The Trustees must necessarily set the policies of the hospital based on the type and quality of hospital desired. Naturally wise Trustees secure proper advice from qualified individuals in all areas of hospital operation.

Hospital Trustees are operating the 5th largest enterprise of the United States.

The administrator of a hospital must operate under the policies prescribed by the Board. In the realm of staff organization the medical staff and its appointed and elected representatives must also operate within the policies prescribed by the Board of Trustees. This is a fundamental point that must be appreciated by all if a hospital is to succeed and progress. The members of a medical staff should feel secure in that hospital Trustees feel deeply their responsibilities and they are giving the time and leadership so essential to meet the unprecedented problems common to the voluntary hospital in this period of world social and economic stress.

The survival of the voluntary hospital and medical practice as we know it today hangs in the balance. A recent article in Philadelphia Medicine entitled "Health Service in England" states:

> "Voluntary hospitals and private medical practice become history in England and Wales on July 4, 1948. The next morning all voluntary and municipal hospitals, with their endowments, plants, movable property, and liabilities, will be vested in the National Minister of Health, who becomes responsible for 'comprehensive health service' for the entire population."
>
> "The voluntary hospitals of England were stifled by the inertia and tradition of their medical staffs and Trustees."

However, progressive American voluntary leadership, coupled with our fine tradition can produce a pattern for the future to meet every health need of our people on the voluntary basis that has been so successful in our Country.

The overall economics of hospitals in general are today under discussion. The per diem cost has advanced, but no more than in other services and commodities. As a matter of fact, statistics presented by Frank G. Dickinson, Ph.D., Director of the Bureau of Medical Economic Research of the American Medical Association, indicate that the people of the United States are today better able to meet today's cost of hospital care than they were able to meet the costs in the 1930's. Americans spent twice as much for jewelry, almost four times as much for tobacco and nine times as much for alcoholic drinks as for hospital care. In the middle 1930's 8/10 of 1% of income was spent for hospital care, whereas in 1945 only ½ of 1% was so spent. It is a paradox, perhaps, that the high hospital rates of 1945 were less burdensome than the low ones of 1933, but it is true. This happens because the country's personal income has climbed even faster and farther than hospital rates have climbed.

continued on next page

* Presented at the joint meeting of the Rhode Island Medical Society and The Providence Medical Association, at Providence, February 2, 1948.

Hospitals must operate on a financial plan that does not dissipate endowments. The Federal tax structure has resulted in fewer large sums being available to assist in meeting day by day financial operation. Government, must, therefore, begin to pay adequately for those members of the community for whom it has accepted responsibility.

This over-all economic problem of present day hospital management must not be allowed to distort our long-term thinking on such fundamental subjects as graduate medical education.

Phases of Graduate Medical Education

Graduate Medical Education, or specifically the training of Interns and Residents, has always been a function of hospitals. The Council on Medical Education and Hospitals of the American Medical Association states:

"The internship is one of the most important phases of Medical education. Internships designed without a well supervised educational program, or arranged merely to provide hospitals with resident personnel to relieve visiting physicians of tasks which they do not wish to perform, cannot be approved.

Basis of the Internship: The internship is a form of apprenticeship. The intern assists in the care of patients and receives in return instruction from the hospital staff in the clinical and laboratory aspects of his profession."

The report of the Commission on Graduate Medical Education, published in 1940, says in connection with Interns:

"The internship, which is designed to round out and unify the physician's undergradute education as this applies to actual practice, by its very nature requires close supervision of a definitely educational character. This implies that the intern's teachers will be concerned primarily with aiding him to understand the patient as an individual and to appreciate the painstaking nature and vital necessity of a good history and physical examination leading to an accurate diagnosis. The teachers should not lay stress upon the detailed technics of the specialties, even though in some instances these may be the most dramatic elements in the care of the case.

Improvement in its educational content is today the most important problem of the internship and one of the most important in the whole field of medical education. This educational content should be a vital factor in determining a lifetime habit of study. Obviously no formal course of didactic lectures or of laboratory opportunities is going to create automatically a genuine and continuing interest in self-education when no such interest exists. Such an interest must be either born in a man or created by his contacts with great minds. When such an interest has been created during medical school days, the internship should do everything reasonably possible to nurture and to stimulate it.

The internship and residency offer to hospitals the best opportunity to inculcate in the physician of the next generation an understanding and appreciation of the need and value to him and his patients of hospital procedures and routines. If this opportunity is missed, some hospital may be forced to work with an unsympathetic staff man for twenty-five or thirty years."

What does the hospital offer the intern in the way of further opportunities to study and to learn medicine? This question is well answered in "Medical Education and the Changing Order" by Raymond B. Allen, M.D., now President of the University of Washington and published in 1946 under the auspices of the New York Academy of Medicine, and I quote:

"First and foremost it affords an ideal opportunity for him to apply and develop his knowledge and skill in diagnosis and treatment under the watchful eyes of experienced physicians. Thus he takes another carefully supervised step toward independent responsibility for the life and welfare of patients. It is this kind of experience for which the eager student of medicine has been striving ever since he decided to become a physician. If his undergraduate education has been sound and inspiring, and if during his internship he has the good fortune to come under the influence of good clinicians who like to teach, a vital education experience is assured. In the absence of either of these elements, that is, an eager well-educated student and an experienced clinician who enjoys working together with students, any amount of organization, rules and regulations, required lectures and seminars, reports and grades will fall far short of anything like the ideal.

There is little doubt that some internships fail even to approach such an ideal. The fault lies with medical schools which select students poorly adapted to medicine and then fail to provide an adequate medical education, and with hospitals which do not recognize that the internship is an important, indeed critical, part of their responsibility to patients and to the whole educational process. Hospitals which fail to perceive their role in medical education and think that they have discharged their obligations to the intern by providing suitable living quarters, recreational facilities, perhaps a small stipend (in general, the poorer the internship the larger the

stipend), an opportunity to write histories and do physicals, make hurried rounds with a busy practitioner, hold retractors at operations, and carry out other routine functions, have no place in any plan of genuine internship education. The spread between high-quality educational internships and those which merely satisfy formal, so-called minimum requirements is very wide indeed. A regrettable aspect of the whole situation is that the weaker students often have no alternative but to take the poorer internships, thus further complicating an already difficult educational problem. The internship experience should strengthen, not weaken, the student's appreciation of high scientific and ethical standards of practice. The quality of staff and interns determines the quality of the internship, just as the quality of faculty and students determines the quality of an undergraduate teaching program.

Gradually it has become evident that rotating internships were degenerating into a merry-go-round of kaleidoscopic impressions of medical practice with undue emphasis on its technical aspects, and it is now generally recognized that the internship should be concerned primarily with the study of patients as persons, the natural history of their diseases, and the appropriate regimens of treatment. With the patient as the unit of study, the internship is gradually being reoriented and rearranged so that interns can broaden and deepen their knowledge of men by studying them intensively when they are sick."

These quotations represent selected sections from three publications all of which are the results of study by recognized national leaders in medicine and medical education.

Internships in New England

The Medical schools of this country, 77 in number, have a budget in 1948 of forty-three million dollars and with fees from students of but twelve million. In other words, the average cost per medical school student per year is about $1,700, whereas the student payment is about $500 per year. These schools are both charitable and governmental. The remaining funds, therefore, come from endowment, contributions, and from tax sources.

There are 24,000 medical students with 5,716 to graduate in 1948. Of these 1,549 are enrolled and 397 will graduate from medical schools in New England this year. It is conservatively estimated that 50% of the 4 years in medical school is spent in some 300 hospitals. These young men of medicine, after completing medical school then receive their graduate medical education in more than twice as many hospitals.

There are 6,280 hospitals in the United States registered by the American Medical Association with but 764 approved for intern training with a total of 8,539 approved internships. A study of approved internships in New England reveals that:

89 7/10 per cent of New England Hospitals approved for internship training are voluntary hospitals.

72½ per cent of interns trained in New England are trained in voluntary hospitals, the remainder in government hospitals.

New England Hospitals in general must, therefore, attract graduates from medical schools outside of New England as there are 286 more internships than men seeking them.

This presents a great challenge to the New England non-university hospitals as not only are there more internships than interns in New England, but also throughout the country. With 50 per cent more internships than interns, the competition for interns is naturally keen.

Hospitals are competing in the realm of training programs.

Voluntary Hospitals Lead in Education

This data demonstrates that a very high percentage of graduate medical education as well as the portion of undergraduate medical education carried on in hospitals is carried on in the voluntary non-profit type of hospital.

This establishes the fact that as the public, through contributions and payments for hospital service, has financed the voluntary hospital so the

continued on next page

From American Medical Association August 16, 1947

State	Hosps. Approved	Internships Approved	Voluntary Hosps.	Voluntary Internships	Government Hosps.	Government Internships
Massachusetts	39	417	33	241	6	176
Rhode Island	4	42	4	42		
Connecticut	18	185	17	173	1	12
Maine	4	21	4	21		
Vermont	2	9	2	9		
New Hampshire	1	9	2	9		
TOTAL	68	683	61	495	7	188

public has paid the cost of the great volume of medical education that has been and is being carried on in the voluntary hospitals of this country.

Medical school faculties know the hospitals where a good intern training program is available. Young men in training pass the word along. Their criteria is the educational program as applied to this level of graduate medical education.

The factors used by the AMA and ACS in determining approved hospitals are the very items which the faculties and the medical students value. The percentage of autopsies, the kind of staff structure, the scope of laboratory and x-ray departments as indicated by statistics in comparison with patient days of service, the number, kind and quality of scientific meetings, the quality of medical records and the scope of professional audit—these factors which you men know so well, are the factors that mean so much to prospective interns when they are selecting the hospital in which to pursue their graduate medical education.

The national bodies referred to above have done much to improve the quality of American hospitals both as to service to the patient and education. It is natural and proper for Hospital Trustees and Staffs to wish to live up to the minimum standards required. The leading hospitals in the country naturally forge far ahead of the minimum standards.

Trustees in selecting men to head up medical departments must naturally give consideration to many factors if the hospital is to have leadership, not only in the individual care of the patient, but in the graduate medical education program which is a necessary adjunct to patient care.

In our own State of Rhode Island there are four hospitals approved by the American Medical Association for intern training and all are voluntary non-profit hospitals, namely:

Memorial	6
Rhode Island	24
Roger Williams	6
St. Joseph's	6
TOTAL	42

As there is no medical school in Rhode Island, it is necessary for these four hospitals to look to medical schools in other States. However, this is also true of certain other States in New England and other areas.

The Resident Training Program

The medical profession of this country, appreciating the growing complexity of modern medicine and realizing the need for a special training in certain areas of medicine set up Resident Training Program.

In Rhode Island, exclusive of Psychiatry and Tuberculosis, there are twelve Residents graduated per year.

The Master Plan of the Hospital Council of Greater New York calls for a resident training program to produce specialists in direct relation to the needs of the people. The Rhode Island Resident Program, after making adjustments for variance in population is producing but ½ of the requirements set by this New York Plan.

The compactness of our State and the small number of hospitals participating in this graduate education program together with the presence of several Colleges should make possible a fertile field for successful internships, residencies and a program of continuing education of the practicing physician.

The use of several hospitals in rounding out a resident program is practical as demonstrated by the Residents in Pathology at the Rhode Island Hospital who gain experience by activity in 6 different hospitals of the State.

This could be followed in other specialties if through staff organization selected staff members of the participating hospitals could be integrated in the over-all teaching program of the central hospital. It cannot now be worked out on the intern level except for affiliation to round out training for general practice. The general and specialty hospitals of this area by joint effort could do an outstanding piece of work in training men for general practice.

The four Rhode Island Hospitals approved for Intern training will secure interns only if an educational philosophy prevails within the hospital. This will require a desire to teach on the part of the medical staff; support of the program by the Trustees, not only moral support, but adequate financial support and leadership by the Administration of the hospital.

The organization and direction of the internship program by the Hospital Administrator is just as definitely an obligation as is the organization and direction of the undergraduate medical teaching program by the administration of the medical school.

Relation to Hospital Economics

How does all this relate to the hospital economics? Should the patient pay for the cost of the intern and resident training program?

There are not many who have raised this question and there is not agreement that the point should be discussed.

It is an acknowledged fact that graduate medical education is an integral part of patient care. It cannot function without patients. Patients who participate receive a better quality of care. A hospital with an educational program provides better

care to all patients. Without education the hospital cannot progress. The chief gainer when the hospital becomes a teaching hospital is the patient. Dr. Alan Gregg of the Rockefeller Foundation has said: "Teaching is the greatest service and safeguard to the patient which a hospital can provide."

Let us examine briefly the cost to the hospital for intern training. These costs are both direct and indirect.

The direct cost analysed at the Rhode Island Hospital includes housing, meals, uniforms, laundry, hospital care when ill and stipend—for residents only.

The indirect costs are represented by the greater use of hospital supplies, x-ray and laboratory facilities, additional diagnostic and therapeutic procedures, more demands on nursing and technical personnel, library and record department. These factors deserve full consideration when we evaluate the role of the hospital in the educational field and when hospital budgets are prepared, although it is impractical to attach a dollar value or cost, rather it must be interpreted as an investment of the hospital in good training for young physicians. The best service that can be rendered a community by its hospital is contributing to the caliber of its future physicians. However, the visiting physicians have the responsibility of supervising and, yes, of controlling these indirect costs. The use of costly tests without a medical, educational, or research need is an economic waste that must not be tolerated. At the same time those who pay for patient care must appreciate that these indirect costs are proper educational expenses and in the interest of the patient.

There is another aspect more important than these—the contribution of staff members to the education of these young men. You physicians of medical staffs are making one of your many and great contributions to society and to the progress of medicine when you do a thorough and thoughtful job of training your successors.

This contribution is not expressed in dollars as the teacher in medicine gains much from contact with the inquiring minds of young men of medicine. However, it is fair to say that less than ½ the potential cost is all that is being considered when we raise the question: "Should the patient pay the cost of intern and resident training?"

However, let us view the facts of dollar cost for the direct expense to one hospital. The cost of the intern and resident education program at Rhode Island Hospital last year was $67,000, or 2⅜₁₀ per cent of the total operating expense.

The direct cost per intern per year is $1,204.80 and per resident $1,923.70. The indirect cost would add approximately $500 per man per year.

The patient contributes to the education of interns and residents and, if the educational program is well carried out, the patient enjoys and values it. By the same token the intern and resident make a real contribution to care of the patient. A spot check study at Rhode Island Hospital indicates that the average patient receives a minimum of 6 hours of service from an intern during the average hospital stay. A good history and physical requires one hour; surgery requires nearly one hour for pre-operative and over one hour for the operation itself; daily visits, dressings, notes on chart and discharge summary consume another three hours. Many major surgical and involved medical cases require additional hours of attention. A recent consultation at Rhode Island Hospital utilized for 20 minutes the undivided attention of 17 physicians.

The cost per ward patient per day for intern service at Rhode Island Hospital is 61¢ of a total cost per ward patient day of $14.50. Statistics as to utilization of hospitals indicate that about 10 per cent of our people go to our hospitals in a given year. In other words, we might say that once in 10 years each of us is in need of hospital care. The payment of our proportionate share of graduate medical education through a charge for hospitalization, particularly when we have direct benefit, could not by any stretch of the imagination be considered unfair.

Is not continuity of attention, guarantee of continuous availability of medical service within the hospital and out in the community, plus the detailed service per patient as has just been described worth 61¢ per day to the patient?

These hospitals that we have been discussing have certain endowment funds. Some may say charge the cost of graduate medical education to the income from endowment. In other words, use the endowment income to finance the graduate medical education program.

Yes, this may be done, but it will merely be a bookkeeping entry as less funds will be available to meet other patient needs.

In other words, the present procedure is for graduate medical education to be absorbed in general hospital costs and applied to all patients, although many hospitals have erroneously neglected to charge the private patient a fair share.

The major portion of graduate medical education is being carried on in the voluntary hospitals. However, we must not overlook the contention made by Government hospitals such as the Boston City Hospital and the great municipal hospitals of New York City. The quality of our non-profit hospitals results in major part from the educational function so well carried out. We do not wish to sacrifice the quality of our voluntary hospitals by forfeiting to government hospitals the

continued on next page

educational function. Whether we buy an automobile, a radio or a bar of soap we pay for the education and research that has gone into the production.

SUMMARY

If we are to continue to improve the quality of service to the sick, we must safeguard the financial structure of our voluntary hospitals and we must accept the fact that graduate medical education is an integral part of patient care.

Originally, young men of medicine paid for experience in a hospital. However, the great bulk of graduate medical education in this country has been financed by the supporters, including the patients, of the voluntary hospitals. It is a fundamental fact that graduate medical education and patient care must go hand in hand and thus the hospital is the only practical instrument for teaching doctors.

Present-day hospital costs are the result of the progress of medicine as much as the result of price spiral. These present-day hospital costs are, therefore, probably here to stay and, because of the lack of understanding of these costs and our general social upheaval, the question as to the proper procedure comes up for review.

Who should pay for graduate medical education? The decision can be selected from the following possibilities:

1. The intern, by paying tuition.
2. Government to finance by concentrating this activity in Government Hospitals.
3. Philanthropy or endowment by specific educational grants.
4. The patient or third party payee such as Blue Cross.
5. Or, we can follow our present system whereby the patient and philanthropy share the cost.

Although the answer seems obvious to many, it is apparent that there is need for clarification of this important subject of graduate medical education and hospital economics. This topic warrants the careful and judicious thought of groups such as the Rhode Island and Providence Medical Societies.

POSITION OF THE GENERAL PRACTITIONER TODAY

concluded from page 170

It is to be hoped that these adjustments which have been made necessary by the changing order will restore to the general practitioner his rightful place within a medical profession in which no one group dominates but in which all are united for a common purpose — the best possible care of the patient.

The RHODE ISLAND MEDICAL JOURNAL

Owned and Published Monthly by the Rhode Island Medical Society,
106 Francis Street, Providence, Rhode Island

THE RHODE ISLAND COLLEGE OF PHARMACY

In the early days of medicine the compoundings of drugs and their administration to the sick were accomplished by the same individual. The old time physician and apothecary were one. At the present time not only does the doctor find his own profession broken up into a group of specialties but he recognizes pharmacy as a separate and allied profession on the achievements of which he is dependent for much of the wherewithal that he requires in the application of modern treatment. Both medicine and pharmacy have gone a long way and the elaborate technics involved in their work make necessary a diverse and specialized training for each.

The Rhode Island College of Pharmacy, which graduated its first class in 1903, is now conducting a drive to raise funds for a building adequate for its needs. This effort deserves the hearty support of the medical profession. As allies of the physicians of our state the graduates of this institution have carried on their work with skill and integrity which justifies the confidence of all our citizens. The standards of their training are high and they share with us of the medical profession the lofty ideals of service which should govern the care of the sick throughout the civilized world. They work in many fields including not only that of the prescription pharmacist but also as workers in the laboratories of Health Boards and in the broad field of pharmaceutical research.

With the recent advances in therapy, particularly in the field of chemotherapeutics and antibiotics and also along other lines as well, no doctor need to be told of his absolute dependence upon those who prepare and furnish to him the various medicaments which he must use.

It is with pleasure, then, that the JOURNAL extends to President Claflin and his co-workers congratulations on their accomplishments in the past and the hope that their present efforts will lead to the means of still greater achievement in the future.

WOMEN PHYSICIANS

For the second time within three years a district medical society in Rhode Island has honored a woman physician with its presidency. In 1945 it was Washington County that named Dr. Frances A. Kenyon as its leader. In 1948 it is Kent County to the fore with Dr. Jeannette Vidal.

The honor to Dr. Vidal is particularly significant in view of the fact that the Kent County Society has taken leadership in the campaign for a hospital in that area, and with the fund raising phase of the program being launched this month the president of the district medical society is certain to draw added important duties. That Dr. Vidal is well qualified for her post cannot be denied. She served as an active member of the committee on public laws of the state medical society for two

continued on next page

years, and she has been the efficient secretary of her county society during the same period of time.

It is just such action as this naming of capable outstanding women physicians to position of organization leadership that demonstrates one distinguishing feature about medical groups. When work is to be done the task is to the willing and the capable, and politics and sentiment are relegated to the background.

To our loyal women physicians in Rhode Island, headed by Dr. Margaret Hardman who was honored at the recent Providence Medical Association Centennial for her distinguished service as the oldest living member of that society, the Journal points with great pride.

CENTENNIAL

The celebration of the Providence Medical Association went off in a wonderful manner. The committee in charge headed by the President, Dr. Philip Batchelder, and aided by the executive secretary, who, as Dr. Batchelder said, might appropriately have received along with his doctorate a master's degree — Master of Detail — made so far as we know not a single slip nor left anything worth while undone.

The Wyeth Corporation kindly lent their series of historical medical paintings by Dean Cornwell which were displayed in commercial establishments. The prize poster by which Mr. Adolph Jeff won the competition among School of Design students was of course prominently displayed throughout the city.

One of the chief features incorporated in this was the seal of the Providence Medical Association which was designed by Mrs. Howard D. Day seven years ago. It most appropriately depicts Roger Williams and a companion being greeted by Indians as they landed here. Entwined about this are formalized serpents of Aesculapius. The wording is in keeping with these days when the classical languages are decidedly in the discard.

We have not heard a dissenting voice regarding the excellence of the dinner and meeting on January 31, the hundredth birthday date. An efficiency engineer could not have found room for more in the dining hall. The hotel outdid itself in the quality of food and service. The liquid refreshments produced just the desired effects and no more. The state and city executives were graceful in their oratorical offerings.

Dr. Ruggles, the President of the State Society, presented certificates to the past and present officers with an urbanity and light touch that made the ceremony pleasing to the onlookers as well as to the recipients of awards. A surprise feature was a reproduction of the original meeting of the Association. The bewhiskered and frock coated members were highly diverting if not familiar to the modern audience.

Having reported all this with genuine enthusiasm we are now moved to some decidedly adverse remarks. The highlight of the entire celebration was, as it should have been, the talk at the medical library in the afternoon by Dr. Reginald Fitz of Boston. Dr. Fitz paid us a great compliment. He did an enormous amount of work to become acquainted with our history and carry through research on obscure points.

But Dr. Fitz is no Jonas Dryasdust. His talk was as bright as Joseph's coat of many colors. As it is printed in this Journal, you will see the firm warp on which he embroidered a brilliant woof lost now except in the memory of the fortunate few who attended. Four hundred and twenty-five people came for the food and drink at the hotel. Possibly one-fifth of these had the far richer feast Dr. Fitz furnished. As Sam Weller's old lady said when she kissed the cow, "Everybody to their own taste."

Congratulations to the Providence Medical Association as it starts with a rush for 2048.

TRUTH AND CIRCUMSTANCES

"A man must not always tell all, for that were folly: but what a man says should be what he thinks, otherwise 'tis knavery."

MICHEL DE MONTAIGNE

There are certain perennial ethical questions, not usually covered in formal medical curricula, which confront each new crop of physicians. Sometimes they are incidentally, and somewhat casually, discussed in the course of clinical instruction. Sometimes they are not even mentioned. One of the most important of these questions relates to the discussion beween patients and practitioners concerning their ailments after such examinations as are necessary to reach a diagnosis have been completed. The subject has been discussed from time to time in medical essays or books, by Alvarez, for example, in his "Nervousness, Indigestion and Pain." The problem can be summarized in a few words: shall the physician always tell the patient the truth regarding his illness even though it be a serious, perhaps a necessarily fatal, one?

There are several factors to be considered in attempting to reach a conclusion as to the general principles which should govern this situation. In the first place it is fair to point out that, as the result of inherent difficulties in diagnosis, the physician does not always know the truth and that, even in the simplest case, he can but express the truth as he sees it, inevitably colored by his judgment and his personality. Then again, to use the well-known legal phrase, should he tell "the truth,

the whole truth, and nothing but the truth" or should he, in certain circumstances, shade or euphemize his statement to the patient?

From the ethical point of view there are cogent reasons why physicians should be frank and open with their patients. As Francis Peabody once said: "the essence of the practice of medicine is that it is an intensely personal matter," and it is difficult to conceive of patients maintaining satisfactory personal relations with doctors who are habitual liars. Even though it be true, as the psalmist said, that "all men are liars", he admitted that he made the statement in haste and many men indulge in mild social fibs only and would scorn habitual deception in matters of such vital importance as health. Mutual confidence between physician and patient is often an essential element in securing the best therapeutic results, even in these days of specific therapy, not only because of its psychic effect but also because, in intelligent patients, better cooperation is obtainable if the person under treatment has clear insight into the nature of his trouble. Nor should we overlook perhaps, in a discussion of this kind, the detrimental effects on the character of the doctor who pursues a policy of habitual mendacity.

The reason for shading the truth or using euphemisms in some cases is a psychological one. There are many nervous patients who react unfavorably to the plain, unvarnished truth, mainly because certain diagnoses have come to have an ominous significance to the average or even the highly intelligent among the laity. To bluntly tell a nervous patient that he or she has a cancer or angina pectoris may result, as I have personally observed, in rapid downhill progress in the case of a neoplasm or the development of an anxiety psychoneurosis in a patient with coronary disease. Furthermore not all patients desire to hear the naked truth and some of them are not sufficiently intelligent to grasp its implications. On the other hand some patients insist that they be allowed to face the facts and such requests should be granted, albeit the subject should be presented with tact and sympathy. After all, in the presentation of truth the manner is often as important as the matter. Some of the older readers may recall that once popular Cockney song of Albert Chevalier the refrain of which was "it ain't exactly wot 'e sez, it's the nawsty way 'e sez it." Needless to say, the family should always be told the whole story. We may well sum up the matter in the words of Mark Twain: "When in doubt tell the truth."

G.B.

KENT COUNTY HOSPITAL

For the next few months an active campaign will be in progress to raise $800,000 to finance the erection of the Kent County Hospital to be located on Toll Gate Road, midway between Westcott and Apponaug. The campaign comes in the midst of a period when the public generally is under solicitation for many worthy charitable causes, and at a time when experts note a decided decrease in the size of contributions.

A campaign to erect a hospital is more than a mere contribution for a worthy charitable cause. For the people of Kent County the hospital is a vital investment in community health and welfare, an investment that ranks equally with the school, the fire, and the police systems.

The excellent state highways that have enabled the city worker to move his residence outside the Greater Providence area have also encouraged the policy of speeding the patient needing hospitalization to the institutions within the City confines, thus furthering the overcrowding of them. It is encouraging, therefore, that the city of Warwick and its surrounding towns have accepted the responsibility for providing a hospital local to Kent County.

The area to be serviced has grown in stature in recent years. An estimated 60,000 persons reside within the County. Even the County Medical Society has noted a decided increase in membership with thirty-four physicians now on its roster, a fine nucleus for the staffing of the new hospital.

In an era when philanthropy is laid low by taxation, when other states look to the federal government for funds to meet local expenses, the voluntary process is tested again in Rhode Island. We are sure that people throughout the state will join with the citizens of Kent Couny in generous support of their hospital program.

ADMISSION TO MEDICAL SCHOOLS*

DWIGHT O'HARA, M.D.

The Author. *Dwight O'Hara, M.D., of Boston. Dean, Tufts College Medical School.*

WHEN I RECEIVED this assignment I went to the chairman of our Admissions Committee, asking him what he thought I ought to say. He replied that there really isn't much to say on the subject of admission to medical schools; either you get admitted or you don't, and that's all there is to it.

* * *

In its present form the professional aptitude test used by the Association of American Medical College is one year old; in the medical schools we are now dealing with the second generation of those tested. We consider it an improvement over previous aptitude tests, but it is still a test that tends to determine facility of memory and past exposures rather than creative or constructive ability. One of the members of our Admissions Committee has been curious enough to take this test—(I am sorry I am not free to divulge what the scores indicated concerning this individual, but you might be surprised, as he was, by the implication of what the college senior is expected to have packed away by the time he applies to enter medical school). After taking the test, our faculty member gave us this tip — which I am glad to hand on to you — that the best possible preparation is to faithfully read every copy of the Reader's Digest for the past ten years! He does not think that this will insure a high score, merely that it will help in preventing one that is too low.

In general aptitude tests are disappointing because they cannot approach a given vocation with the infinite variety of aptitudes which individuals seem to bring to bear upon the same vocation in practice. The truth is that not one, but many aptitudes are applicable to most vocations; too many to test with any prognostic finality. I do not mean to imply that we do not consider the aptitude test as a distinct help in reaching decisions. We try to make it confirm the other evidence presented by each individual applicant, and it frequently does this in a very satisfactory manner.

It is generally thought that a first degree insures a certain amount of culture, as well as the scientific preparation for the work in medical school. This is what we all hope, and it is probably a fact that a college training does insure a broadly cultured individual insofar as anything can insure that desirable product. There has been a good deal of discussion about this among medical educators, but I believe they might better approach agreement in their views if they could confine themselves to a consideration, not of whether their candidates have acquired "culture" or been "educated", but whether they have sufficiently *matured* to be able to adapt themselves to the study of medicine. Maturity is used here to describe a combination of seriousness and wisdom that comes with the passing of time; to some it comes early, to others late. We have now seen many instances in which maturity did not appear in a good college environment, but quickly came when the individual left that environment to enter the rough and tumble of military service. Some people never mature, regardless of age or academic or other exposures. Because an arbitrary standard has to be set somewhere we feel that the academic exposure necessary to qualify a person for the first degree is a good requirement to apply to the large number of present day applicants. As always there are conspicuous exceptions, and our Admissions Committee may permit special conditions to apply to special cases; in general however it sticks to the requirement of a degree and selects its students from among applicants who expect to receive a degree with the completion of their premedical work.

What courses to elect other than the orthodox English, Biology, Chemistry, Physics and Language is not important. At Tufts we also require an elementary course in Psychology. This is sometimes accounted for by the fact that the President of Tufts College is a psychologist, but the psychology requirement was instituted by Dean Stearns before President Carmichael assumed his present position, and was based on Dr. Stearns' belief that an elementary insight into normal motivation and reaction is essential to an understanding of the behavior of the sick. Many seem to think that a

continued on page 188

* Excerpts from a lecture presented at Brown University, Providence, on January 6, 1948, as part of a series on Medical Education offered by the Department of Medical Sciences.

ADMISSION TO MEDICAL SCHOOLS

continued from page 186

mediocre scholastic performance in the sciences may be counteracted by a large volume of science courses, but this is not so. Straight B grades in anything are preferable to C grades in a top-heavy scientific program. After one has corrected a batch of examination papers he is inclined to agree with the chemistry professor who said he didn't care what subjects were required for premedical study, if only the students could be taught to read and write the English language. Certainly there are plenty of graduates of both colleges and medical schools who are illiterate in the sense that they express themselves awkwardly. Today the doctor is being forced into a position of leadership which requires him to be able to utilize to the utmost this medium of expression upon which we must depend to make ourselves understood. In matters of health the doctors should be the leaders.

The power of properly used English not only to express opinion as it may relate to pertinent facts and procedures, but scientific wisdom as well, is an essential tool if the doctor is to shape the conditions under which optimum health can be attained.

* * *

I notice that previous lecturers have talked of medicine in the present and future. If you will excuse me I would like to speak of yesterday in terms of my own experience. Previous to graduating from medical school I had always intended to practice general medicine, but four years in a school in which I didn't see a single general practitioner frightened me enough to form a loose partnership with a colleague who had had a surgical training. Between us we were self sufficient. In the twenties we thought we knew all there was to know.

I look back upon that decade as the period in which I learned more, per year and per unit of effort, than was the case either before or since. We learned things about medicine that were not in the books and that were contrary to the authoritative statements of the day. We discovered what appeared to be new diseases; I recall one the blood specialists of the early twenties knew nothing about but which we later found had been beautifully described as "Puerperal Anhemia" in 1842 by Walter Channing. A single text, the Principles and Practice of Medicine, by Osler was our Bible; in it we seldom failed to find an answer. I recall a tracheotomy on a kitchen table, visiting homes on snow shoes, post morten examinations in the master bedroom and other incidents of a medical life that has all but disappeared, even in rural regions. Indeed, in many rural areas now all medical life has disappeared. We learned a great deal from older doctors; men who were already what we thought to be a little old fashioned, but who had had years of experience with sick people. When the adjective *psychosomatic* was recently coined I had difficulty in understanding why it suddenly seemed a popular thing to talk about, because in the twenties it was what every doctor knew. The reason an old concept could thus be suddenly popularized was that a whole generation of doctors had been carefully shielded from knowing the ordinary facts of life by intensified attention on the part of their teachers to the reactions in test tubes and experimental animals. It is so apparent that something has thereby been lost that I would like to make the point that we should not turn our backs upon the past.

* * *

The art of understanding people and the complex situations in which they find themselves is not an easy one to acquire. It calls for much hard work. The doctor must be a person who is willing to do this work, not one who seeks to find an easy answer. The doctor is now being called upon to be a sociologist as well as a physician in his outlook. The narrow fields now being cultivated in medicine, surgery or any of the specialties are not broad enough to retain a full professional status for their practitioners. Without a social point of view these specialties are trades.

Look at this great atomic threat under which we now live from day to day! The scientific teams which made the bomb have already turned to the medical profession to justify the prodigious cost to which they have committed mankind. One seldom hears this frightening subject referred to without the ameliorating sop that we can learn to use our knowledge to *save* life instead of destroy it. It has even been stated that already as many lives have been saved by this knowledge as were lost at Hiroshima. This is of course ridiculous; the fact is that we know next to nothing about the beneficent aspects of this knowledge; we hardly know how to protect ourselves against accidents in its use. Here is a challenge however that medicine must meet if it expects to remain a profession. Can such a challenge be met? If it can it will be not by the doctors of today but by the oncoming generation, by those who are today being admitted to the medical schools of the country. The medical schools are recruiting the profession of the immediate future, which brings us back again to the subject of the evening.

I hope you will not feel that I have put myself on one side of a fence and you on the other for that is not the spirit of the medical schools and of course it is not the purpose of this meeting. Perhaps I can be most useful by giving you a few suggestions, and then try to answer questions.

continued on page 190

ADMISSION TO MEDICAL SCHOOLS

continued from page 188

Although a certain degree of scholastic proficiency has to be demonstrated, none is admitted on grades alone; the medical schools try to secure a composite impression of their candidates. Admission committees will be interested in your background, your physical condition, your general appearance and behavior, your age, your past experience, your nervous stability, your professional aptitude and graduate record examination scores, what courses you elect and why, your extracurricular activities, the opinions of people who have really had an opportunity to know you (not your back slappers), your status as a veteran, whether you are married and if so what your financial planning is, your own reasons for wanting to study medicine, the legibility of your handwriting, or anything else that may help them to see you as a complete individual.

Most medical school admission blanks call for a passport type of photograph. Be careful about this. We are not all "photogenic", and a camera may or may not give a good impresson; don't use a picture that gives a poor impression. If you are asked to appear for an interview it will probably mean that acceptance of your application has already been carefully considered. It is possible to make a poor impression at an interview, by sloppy clothes, by cocky manners, by assumed attitudes and sometimes perhaps by just being frightened and nervous. The interview is not an examination; you need not prepare for it in any way. Go to it as you would go to church, or as you would go to call upon your best girl friend; just be natural and straightforward. If you are a natural and straightforward person, can get along with your associates, are nervously stable and can do B grade work on a full sized academic schedule, you are the kind of person the medical schools are interested in. Whether they will be interested enough for one of them to accept you will depend upon how you measure up in the competition. It is a competitive profession in a competitive world.

DISTRICT MEDICAL SOCIETY MEETINGS

KENT COUNTY MEDICAL SOCIETY

The annual dinner meeting of the Kent County Medical Society was held at the Greenwich Club, East Greenwich, Rhode Island, the evening of December 9, 1947.

Following an excellent turkey dinner the meeting proper was called to order at 10:15 p.m.

Dr. John Mack read the yearly treasurer's report and noted that a few members of infrequent attendance were delinquent in dues for two or more years. Upon this information a motion was carried that the secretary notify the physicians concerned that they are automatically suspended and are not eligible for reinstatement until dues are brought up to date. It was further decided that physicians so delinquent who are also members of the state society or hold hospital appointments shall be reported as members not in good standing locally to the state society and the hospitals concerned.

Retiring president, Dr. Peter Erinakes, presented a paper entitled, "What Does the Future Hold for the General Practitioner." In it he noted that to retain the prestige of the family doctor the present day general practitioner must modernize his methods of diagnosis, therapy, and equipment and choose a faithful and efficient staff to aid him.

Officers for the year 1948 were then elected and consist of the following:

President:	JEANNETTE E. VIDAL, M.D.
Vice President:	JOSEPH K. HARROP, M.D.
Secretary:	FRANCIS D. LAMB, M.D.
Treasurer:	JOHN A. MACK, M.D.

It was decided that remaining committees and chairmen for the coming year would be selected at the January meeting.

Dr. Erinakes offered the continued use of his office for society meetings. A rising vote of appreciation was extended him for past use and his offer was accepted.

A final motion was carried that the secretary send the list of active members to Mr. John E. Farrell, executive secretary of the Rhode Island Medical Society, for the purpose of considering one as an additional delegate to the state medical society. The meeting adjourned at 10:45 p.m.

* * * *

No formal January meeting of the Kent County Medical Society was held because of generally inclement weather.

A guest speaker, Dr. Harry L. C. Weyler, gave an interesting talk on "Heart Sounds and Their Clinical Significance," to a small group of members who attended an informal gathering the evening of January 13 at Dr. Peter Erinakes' office.

FRANCIS D. LAMB, M.D.
Secretary

NEWPORT COUNTY MEDICAL SOCIETY

A meeting of the Newport County Medical Society was held at the Newport Hospital on Tuesday evening, January 27, 1948.

The meeting was called to order at 9:00 p.m. by Dr. Alfred M. Tartaglino, President.

The minutes of the December meeting were read and approved.

continued on page 195

JEANNETTE E. VIDAL, M.D.
President, 1948
KENT COUNTY MEDICAL SOCIETY

NEWPORT COUNTY SOCIETY MEETING

continued from page 192

A communication was read from Mr. John E. Farrell, Executive Secretary of the Rhode Island Medical Society, regarding the attendance of delegates at meetings of the House of Delegates.

There being no old business, the election of officers was then held and the following officers for the coming year were elected.

President.....PHILOMEN P. CIARLA, M.D.
First Vice President.....HENRY W. BROWNELL, M.D.
Second Vice President.....ROBERT L. BESTOSO, M.D.
Secretary.....JOHN M. MALONE, M.D.
Treasurer.....NORBERT U. ZIELINSKI, M.D.
Delegates.....JAMES C. CALLAHAN, M.D.
LOUIS E. BURNS, M.D.
Councillor.....SAMUEL ADELSON, M.D.
Censors.....NORMAN M. MACLEOD, M.D.
JOHN A. YOUNG, M.D.

The speaker of the evening, Dr. Herman Lawson of Providence, was then introduced. Speaking on "Splenomegaly," he discussed some of the causes, complaints, physical findings and laboratory data in patients with a mass in the left upper abdomen. He mentioned numerous helpful diagnostic aids which might aid in the differential diagnosis of patients with an enlarged spleen.

Following the question and answer period, a collation was served.

Respectfully submitted,
HENRY W. BROWNELL, M.D.
Secretary

PROVIDENCE MEDICAL ASSOCIATION

A joint meeting of the Providence Medical Association and the Rhode Island Medical Society was held at the medical library on Monday, February 2, 1948.

The meeting was opened by Dr. Arthur H. Ruggles, President of the Rhode Island Medical Society, who reviewed the history of the Dr. Charles V. Chapin medal awards. He reported how the city of Providence had in 1943, two years after the Rhode Island Medical Society had instituted the lectures and had heard orations by Dr. Timothy Leary, professor of pathology, emeritus, of Tufts Medical School, and Dr. Edwin H. Place, professor of clinical pediatrics at Tufts Medical School.

Dr. Ruggles announced that medals had been provided now for the first two orators. He then introduced the Honorable Dennis J. Roberts, Mayor of Providence.

Mayor Roberts briefly reviewed the contributions of Dr. Chapin in the field of public health and cited the debts that the city of Providence and the Chapin Hospital, as well as the medical profession owe to Dr. Chapin. He reported the action of the City Council of Providence in enacting an ordinance to establish the Chapin medal award, and he expressed his personal pleasure in being privileged to present the medal on this occasion to Dr. Edwin H. Place who gave the oration on June 2, 1943, and also, in absentia, to Dr. Timothy Leary who gave the first oration on June 3, 1942.

Dr. Place accepted the medals for himself and Dr. Leary and expressed his appreciation to the city of Providence and to the Rhode Island Medical Society.

Dr. Ruggles relinquished the chair to Dr. Philip Batchelder, President of the Providence Medical Association.

Dr. Batchelder announced that the reading of the minutes of the previous meeting of the Providence Medical Association would be omitted.

Dr. Daniel V. Troppoli, Secretary, read a communication from the Rhode Island Tuberculosis Association announcing scholarships for postgraduate study.

Dr. Batchelder reported that the committee of Dr. Edward A. McLaughlin and Dr. Michael J. O'Connor had filed with the secretary the Association's tribute to the late Dr. George V. Coleman and that a copy of this tribute would be sent to Dr. Coleman's family.

continued on next page

PHILOMEN P. CIARLA, M.D.
President, 1948
NEWPORT COUNTY MEDICAL SOCIETY

PROVIDENCE MEDICAL ASSOCIATION

concluded from preceding page

Dr. Batchelder introduced as the first speaker of the evening Dr. James M. Faulkner, Dean, School of Medicine, Boston University, who spoke on the subject, "The Position of the General Practitioner Today."

The most pressing problem facing the medical profession today is the position of the general practitioner. An objective and open minded discussion will help clarify the situation. The status of the general practitioner has changed since pre-World War I days, and the rise of the specialty boards has produced uneasiness among them.

The general practitioner has seen rank and pay in the armed forces made dependent on board artification and also, appointments to hospital staffs made on the same basis. He feels he is losing his prestige.

A general increase in the standard of living has made possible a shift to the specialist and has lost the general practitioner a portion of his practice. There has been a trend of shifting to hospitals for deliveries and in other fields as well. The Blue Cross has augmented this. The general trend of making staff appointments dependent on board memberships has lost the general practitioner his staff appointment. Too often hospitals have used board requirements conveniently in staff appointments. What is the outlook of the general practitioner for the future?

The general practitioner will continue to carry out the bulk of medical practice. He plays an essential role in the medical profession. He, better than the specialist, can understand the patient as a social human being. There will always be a demand and need for the family physician. What is being done to affect the situation.

Practically all teaching in medical schools is done by specialists. Medical schools could assist by developing in hospitals internships directed for general practitioners. Some teach courses in district medicine in which students make house calls.

A one-year rotating internship is inadequate for general practitioners; it should be at least two years, including one year rotating and the second year devoted to medicine or surgery with second year accepted by a board if intern wants to carry on. Students judge hospitals on the basis of their teaching programs.

Some hospitals have rescinded the rules requiring board artification. Some have added general practitioner sections.

A Specialty board in general practice would not help — it would still leave a vast majority, about 90 per cent, that would not have the requirements. The Board of Internal Medicine has helped by lowering its requirements. Four years of general

continued on page 198

PROVIDENCE MEDICAL ASSOCIATION

concluded from page 196

practice equals one year of residency in board requirements.

Comments on the discussion were by Doctors Halsey DeWolf and Samuel D. Clark.

Dr. Batchelder relinquished the chair to Dr. Arthur H. Ruggles, President of the Rhode Island Medical Society, who introduced the second speaker of the evening, Mr. Oliver G. Pratt, Superintendent, Rhode Island Hospital, who spoke on the subject, "Graduate Medical Education in Relation to Hospital Economics."

Hospitals not only furnish facilities to the surgeon and medical man to give patients the best medical care, but also train young doctors and nurses to serve the community.

The administrator and its medical staff must work under the Trustees who give time and leadership so essential to the hospital.

Hospital rates on the whole have climbed less high than personal incomes. Because of the high income tax, hospitals do not receive large endowments as they once did.

An internship is a form of apprenticeship. An intern receives training for performing tasks at the hospital. A hospital requires supervision of its educational facilities. Seventy per cent of interns are trained in voluntary non-profit hospitals and therefore, hospital cost must include the cost for education of the interns. There are more internships than available interns so now there is competition in getting good interns.

The medical students judge hospitals by their education programs which is an important adjunct to intern training. The Rhode Island Hospital graduates twelve residents a year. This is one-half the required number according to population. Should the patient pay the cost of intern and resident training? The patient who participates receives better care. Without education, hospitals cannot progress. The best service a hospital can give to a community is to provide well trained future physicians for the community.

Dr. John F. Kenney of Pawtucket discussed Mr. Pratt's paper from the medical viewpoint. He laid particular stress on the difficulty smaller hospitals have in getting a quota of interns. He made it clear that unless the medical profession changed their requirements to make this possible the government would step in and assign them.

There was discussion from the floor by Doctors Alex Burgess, Anthony Corvese, and Rocco Abbate.

The meeting adjourned at 11:05 p.m.

Attendance 167. Collation was served.

Respectfully submitted,

DANIEL V. TROPPOLI, M.D.
Secretary

INTERN TRAINING IN THE HOSPITAL SYSTEM*

CHARLES F. WILKINSON, JR., M.D.

The Author. *Charles F. Wilkinson, M.D., of Ann Arbor, Michigan. Assistant Professor of Internal Medicine and Coordinator of Graduate Medical Education, University of Michigan, Ann Arbor.*

IT IS DIFFICULT for me to speak on intern training without considering at the same time training of the resident and the continued training of the practicing physician. I shall, therefore, try to outline certain broad principles that have to do with medical education rather than confining myself to the training of the interns specifically. No longer is it possible to graduate a man from medical school with sufficient knowledge to last him for 30 years, which is about the expected active life of the "lucky" doctors. It is the responsibility of medical schools and hospitals to offer training for the recent graduate of medical schools and to offer opportunities for continuing their education when they enter the private practice of medicine. Let us consider the three ordinary types of internship and then proceed through the logical development of assistant resident, resident, and finally, practicing physician.

The three usual types of internships as offered in America are:

(1) The straight internship in which the intern will devote his entire time for a year or more to one service. This is more common in the East than in other parts of the country.

(2) Some states require that an individual have a "rotating" internship, which means that the intern will spend a varying amount of time on each service in the hospital. This is the usual internship and is what is commonly understood when the term is used unmodified.

(3) Many people feel that a year is too short a time for an intern to adequately cover all services in a hospital, and a combination between the straight and rotating internship is becoming more and more common and is called the "mixed" type of internship. In this type of internship the intern will spend approximately 6 months on one service, and the remainder of his year in closely allied services.

I feel that there is a definite place for all 3 types of internship, but also feel that the rotating internship, if to be best exploited, should probably be for a term of 2 years. The training of the intern in any type of service should be the same in principle. He should be expected to work up cases admitted to his service under the supervision of the assistant resident. He should be prepared to present these cases to the resident or the visiting physician, and it is my feeling that a certain amount of laboratory work is a great teaching aid. I am not in favor of rotating an intern through a laboratory service where he does blood counts and urine analyses from morning until night. I do feel, though, that at his stage of development he should do a blood count and urine analysis on each case that he works up. This presents a difficulty in certain hospitals where surgical patients are admitted in large numbers and late at night and operated early the next morning. The only answer I have to this type of internship is that the intern is being exploited and the hospital and the hospital staff are shirking their duty to the intern.

The intern should no longer be considered a slave. This is considered as well put, for in many institutions he is considered as cheap labor and no responsibility is felt towards him, either for salary that would supply the barest elementary comforts, or for any type of teaching program. In my opinion, these institutions are not training interns and should hire more orderlies and small boys to do their errands, and technicians to do their lab work.

Obligation of the Hospital

Before I can go farther in the duties of the intern, I feel it is necessary to speak of the obligation of the hospital to the intern. He is a Doctor; has spent from 7 to 9 years in acquiring his medical education and is trying to continue to improve it. That is the only reason that he is in the hospital. He is willing to make many sacrifices for good training, as evidenced by many excellent training institutions that pay no salary other than room and board. I do not mention this practice to justify it, but to illustrate how eager the average intern is to obtain a good teaching internship.

The intern should be given time for study and a pleasant place in which to study. The hospital

continued on next page

* Presented at the Third New England Institute for Hospital Administrators, at Brown University, Providence, on June 25, 1947.

libraries should be well stocked with journals and basic text and reference books, and he must not be so tired by the time he gets to the library that he will fall asleep while reading. He should be paid a salary that will at least enable him to obtain some recreation and provide him with bare essentials. I am fortunate in that I only have to recommend that these things be accomplished, and do not have to work out the budget with which they are accomplished. The intern, as I mentioned, should be closely supervised by the assistant resident and by the visiting staff. Each procedure, whether for diagnostic or therapeutic purposes, should be explained to him, even though they appear self-evident to the experienced practitioner.

Minimum Requirements for Teaching Conferences

Certain definite conferences must be arranged for him and he must be given time to attend. I would consider the following as the minimum requirement for teaching conferences:

(1) An X-ray conference where cases are presented and discussed as to why X-rays were necessary. Then discussion by the roentgenologist both from the diagnostic point of view and also from the point of view of the necessity for a given X-ray procedure. In this way the intern will see X-rays on patients he is familiar with and will also have valuable criticism from the X-ray department as to the specific procedure ordered. He will see the need for varying the type of X-ray and on frequently consulting the roentgenologist before they are ordered. He will learn to save the patient unnecessary cost incurred by needless X-rays and will learn a great deal about interpretation of films. A conference such as this should be held once each week in a teaching hospital.

(2) Clinical pathological conferences should be held weekly and should be so conducted that both the resident staff and the attending staff are frequently "put on the spot" as this is one of the most stimulating types of medical instruction.

(3) Clinical conferences should also be held weekly, and the cases presented by the intern. The pertinent literature should be presented by the assistant resident, or resident, followed by general discussion by the visiting staff. It is better, I feel, to make these conferences of one hour in length and to present only one or two cases and have them well worked up rather than having longer conferences or trying to present a large number of cases during an hour.

(4) A Journal Club should be organized and run by and for the intern and resident staff under the supervision of an educational committee or preceptor.

(5) It would seem unnecessary to point out the value of the intern attending autopsies on cases which he has worked up, and if possible, as many others as he has time. The administrative staff should not take a negative or complacent attitude toward autopsies, but should make it as easy as possible for the intern and resident staff to obtain them and be present. Frequently the visiting staff feel that it is not necessary for them to attend autopsies. In effect, this tends to diminish the value of the autopsy in the eye of the resident staff, for he feels that if it were really important, the attending man would be present.

(6) During the year, certain selected topics should be presented to the intern in the form of lectures. These could be at night and need not interfere with his routine house duties. It would seem to me better if these lectures were relatively infrequent and given by an individual particularly well qualified rather than frequent lectures by persons who were chosen for their availability rather than their command of the subject. During his intern year, he will probably not have time to attend many medical meetings outside of his hospital, but if this is practicable, he should be encouraged to go.

(7) Last, and by no means least, is the teaching ward rounds which I touched on when I spoke of the relation of the intern to the visiting and resident staff. If the number of visiting men on the service is large, it would seem best to assign them in rotation to conducted teaching rounds for the entire intern and resident staff of that service. In many hospitals, this is done on the private patients of other physicians. If the ward rounds are conducted so that it is evident that they are being made for the instruction of the intern and resident staff, I do not believe any difficulties will arise in one private physician using another private physician's patients.

The Assistant Residencyship

The second stage in the medical graduate's educational development, if he intends to specialize, is the so-called assistant residency. Here, he is given more responsibilities and in turn assumes the role of buffer for the physician as well as the administrative staff of the hospital. He supervises the intern and it is his responsibility to see that the intern carries out his duties promptly and carefully. The assistant resident should write an admission note on each patient as soon as he is admitted; he should inform the visiting physician that the patient has been admitted and inquire as to the orders that the visiting physician wishes. If the hospital has a large ward service where patients are admitted without their own private physician,

continued on page 204

INTERN TRAINING IN THE HOSPITAL SYSTEM

continued from page 202

then he should turn to the resident who would then notify the attending man, if need be. The assistant resident should be the link between the patient's family and the private physician. He can save the attending physician many worries by assuming this responsibility and can create much good will for the hospital by thoughtful and courteous treatment of the patient's family.

The conferences that were mentioned above should, of course, be available to the assistant resident, and in addition, he should frequently present the recent and pertinent literature at staff meetings so that he may be able to learn the art of public speaking. In large cities, or in hospitals with university connections, a person gifted in public speaking might be asked to address the resident staff and give them some helpful hints, and even correct their faults.

Again, I must stress the necessity of having facilities available for the assistant resident to study, and time allotted for this. It is an ideal time for him to start in some research problem with an older member of the staff; preferably one that he can continue for the next year or two during his training.

Responsibilities of the Resident

The last step in our Doctor's formal educational development is that of the resident. Here, he should have broad responsibilities; be more or less on his own in the Out-Patient Department; act as house consultant for the other resident staffs in the hospital. If he is to be a surgeon he must be given responsibility for certain operative procedures. This, of course, should be closely supervised by an attending physician, but at the same time he should be allowed to do the actual work. If the hospital is connected with the university, he should be employed in the teaching of students and of course in the teaching of interns and assistant residents, whether there are university connections or not. He should be valuable in the teaching program of the nursing school in the hospital and should be given some time to continue the research problem he started the year previous.

I have said nothing so far regarding the basic science training of the intern and the assistant resident. With the requirements of the various specialty boards, this is presenting more and more of a problem. In a university hospital, basic science faculties are available from the medical school, and basic science continuation training may be carried out all through the intern and the resident training period. In a large university hospital, there are usually available individuals who are engaged in fundamental research which is frequently more of a basic science nature than clin-

ical. These people are invaluable in teaching the intern and residents. The problem is quite different in the voluntary hospital that has no university connection. We have attempted to solve this problem in Michigan by affiliating with hospitals throughout the state and aiding them in their resident training programs. We have set up certain basic minimum teaching requirements for these hospitals which are essentially the ones I have described above, and during one year of the resident's training period, we bring him to Ann Arbor where special basic science courses are offered to him. He is in attendance at the University of Michigan Medical School his third year away from medical school. Here his mornings are spent in courses specifically developed for him. He is with a group of other residents. He is not given "rehashes" from sophomore lectures nor is he presented with courses primarily developed for graduate students in the basic sciences, but given courses specifically designed for him. This is one solution to the problem of presenting continuation study in the basic sciences to the resident. There are many others, and a program that seems to fit well in one section of the country is not necessarily designed for another.

In addition to the responsibility for the man during his year at the University, the medical school assumes the responsibility of sending visitors from our staff to the affiliated hospitals to conduct clinics and act as consultants, if desired.

During the resident's last year, he should attend at least one scientific meeting of major importance and if necessary, the hospital should subsidize him to the extent necessary in attending this meeting. More meetings, of course, would be desirable but are frequently not practicable.

What of the General Practitioner?

I have so far dwelt on the training of the intern and resident who is presumably training for a specialty. What of the general practitioner? Is there a need for this type of doctor anymore? Opinions on this point differ widely. It is my belief, and the belief of a large number of the faculty of the University of Michigan Medical School, that it is our obligation to encourage medical graduates to go into general practice. Michigan is largely a rural state, particularly in the northern part of the lower peninsula and in the upper peninsula. It seems to many of us that although group practice may be considered ideal, it will be some years before the rural areas in Michigan can be effectively served by such practice, if they ever can be. We feel that the best answer at present to our problem of furnishing medical care to the rural population is the well-trained general practitioner.

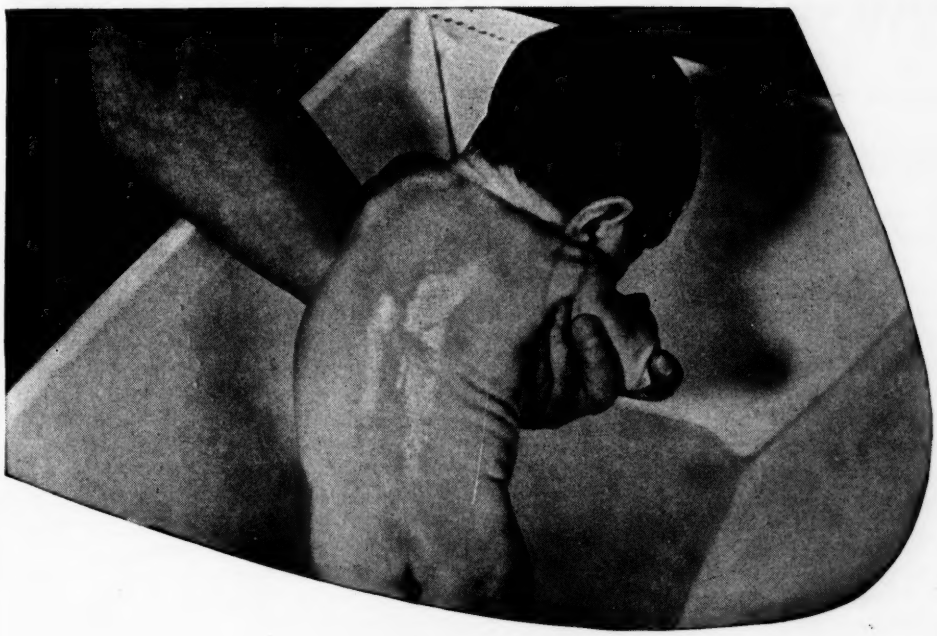
continued on next page

INTERN TRAINING IN THE HOSPITAL SYSTEM

continued from preceding page

We have embarked on a program whereby we affiliate with certain hospitals throughout the state in a 2-year general residency program, specifically for the training of the man who desires to go into general practice. All that I have said before in regard to intern and resident training for the specialist, is equally important in the training of the general practitioner. Our standards for affiliation in the 2-year program are no less high than affiliation for specialty training. The only difference is in the end desired. We insist that training programs of high calibre be inaugurated and as much thought be devoted to them as in the training of the specialist.

I have said much this morning regarding the obligations of the hospital and have dwelt very little on the obligations of the intern and resident to the hospital. My opinion is that when a hospital conducts a good training program it is more than repaid by the type of service given in return by its resident and intern staff. Its patients receive the best medical care possible, and it is fulfilling one of its prime purposes—the training of young doctors, and acting as a medical center for the continuing education of the practicing physician in its community. In this way it will raise the standards, not only of medicine locally, but will continue to the constant elevation of medical standards throughout the country.



First breath, first bath, first bottle

In a life filled with "firsts", baby has no time to cope with such gastro-intestinal problems as carbohydrate fermentation and attendant distention and diarrhea—particularly during his first few weeks.

'Dexin' has proven an excellent "first carbohydrate" because 1) its high dextrin content is not fermentable by the organisms usually present in the intestinal tract, and 2) because it promotes the formation of soft, flocculent, easily digested curds.

Simply prepared in hot or cold milk, 'Dexin' brand High Dextrin Carbohydrate is easily adapted to increasing formula needs from month to month, and later, being palatable but not too sweet, is a welcome supplement to other bland foods. 'Dexin' *does* make a difference.

'Dexin' HIGH DEXTRIN CARBOHYDRATE
BRAND

Composition—Dextrins 75% • Maltose 24% • Mineral Ash 0.25% • Moisture 0.75% • Available carbohydrate 99% • 115 calories per ounce • 6 level packed tablespoonfuls equal 1 ounce • Containers of twelve ounces and three pounds • Accepted by the Council on Foods and Nutrition, American Medical Association.

Literature on request

'Dexin' Reg. Trademark

BURROUGHS WELLCOME & CO. (U.S.A.) INC., 9 & 11 East 41st St., New York 17, N.Y.

INTERIM SESSION OF THE A M A

Report of the Delegate from Rhode Island

HERMAN A. LAWSON, M.D.

THE FIRST INTERIM SESSION of the American Medical Association was held in Cleveland. The House of Delegates met on January 5 and 6. The official details of the business transacted will be published in full in the AMA Journal so that I shall not attempt to give a complete report of all matters discussed. The General Practitioner's Award was bestowed upon Dr. Archie C. Sudan of Kremmling, Colorado.

After a report by the Chairman of the Board of Trustees regarding increased expenses and activities of the national Association, it was clear that the income of the Association must be increased during the coming year. It was therefore voted by the House of Delegates that the annual dues for 1948 shall be $12.00 and that the annual dues be set by the Board of Trustees thereafter, but not to exceed $12.00 per annum.

A resolution was introduced recommending that the Council on Medical Education and Hospitals refuse approval for the training of residents and interns to those hospitals guilty of exploitation of the practice of medicine. It was pointed out that such specialties as pathology, anesthesia, radiology, and physiotherapy constitute the practice of medicine and that there is a tendency on the part of certain hospital administrators to utilize the profits resulting from the operation of these departments in their institutions. Although the House of Delegates disapproves of such practices, it was pointed out that action as proposed by the resolution would probably result in legal action such as has been brought against the AMA previously and the resolution was therefore disapproved.

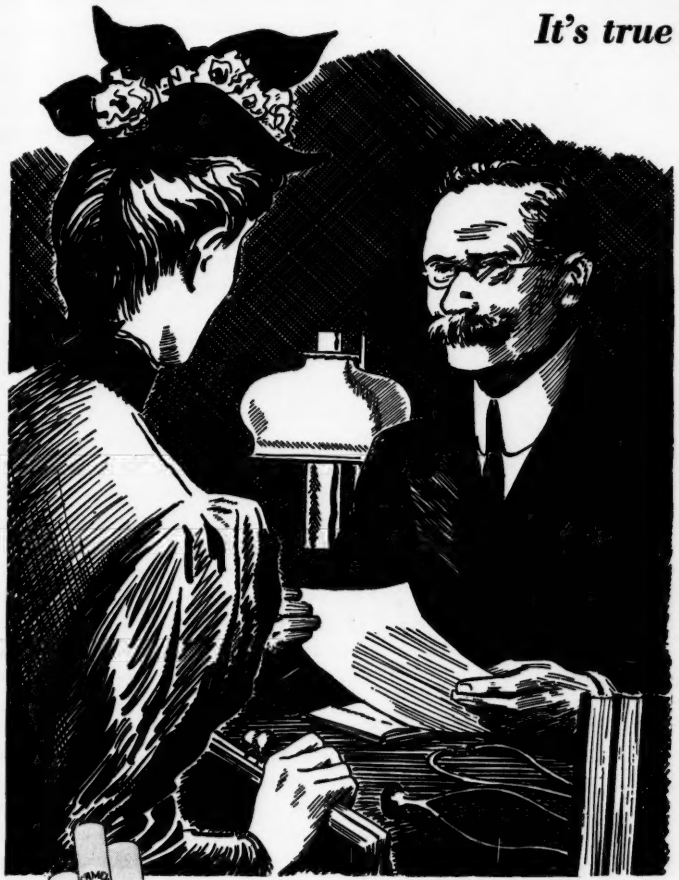
A report of the organization and meeting of the World Medical Association in Paris in 1947 was submitted. One hundred and twenty-five Delegates from 45 nations attended. There were four Delegates from the U. S. The General Assembly of this World Association will be made up of two Delegates from each National Medical Association. Germany was not admitted and the Medical Association of Germany must repudiate war crimes committed by its members and expel those responsible before becoming members of this World Association. The meeting in 1948 will be held in Czechoslovakia. The Delegates from the American Medical Association agreed to raise $50,000 per year for five years by voluntary subscription to aid in the organization, with the provision that the headquarters of the General Secretariat must be in North America. New York City has been selected and the headquarters will be open about the first of March of this year. The General Secretary has not yet been selected. There are to be three assistant secretaries, one English speaking, one French speaking, and one Spanish speaking. It was felt by all those who are interested in the development of this new World Medical Association that it will be of great value in promoting a better understanding between physicians in all countries in the world and an effective force to help maintain world peace.

The President of the American Medical Association, Dr. Bortz, spoke. In his talk he emphasized the tremendous new problems, which this atomic age will produce. Products of atomic energy will be used more and more in industry and there is urgent need for greater understanding by physicians of the hazards involved and the means of protection. He feels that organized medicine must prepare plans for emergencies which may arise from the use of radio-active substances in industry as well as war. He stated that the unprecedented derangements of life that would result from an atomic explosion present a challenge to American medicine, and that doctors, hospitals, and nurses are as a whole not prepared to deal effectively with large-scale disasters. He urged that each state society concern itself with this problem to speed development of essential plans to cope with disasters which we may face in the future.

The Committee to study with the Nursing Problem reported that the serious shortage of nurses is a problem which has not been solved. The committee recommended training of more practical nurses and attendants; that nurses not be assigned improper duties. There was general agreement that more nurses of a lower grade than the present highly trained professional nurses must be trained. They suggested that, in order to attract more young women into the field of nursing, one must provide social security and retirement plans for them. A permanent Conference Committee of five members each from the American Medical Association, American Nurses Association and

continued on page 210

Experience is the Best Teacher



It's true in medicine—

John William Ballantyne

(1861-1923)

proved it in obstetrics

BALLANTYNE, in his early studies of anatomical and pathological conditions found in the new-born, sensed the value of routine prenatal care in obstetrics. As a pioneer for prenatal care he was the first to establish a clinic for the expectant mother. World-wide acceptance of Ballantyne's concepts quickly followed his successful experiences in prenatal supervision.

Experience is the best teacher in choosing a cigarette, too!

MORE PEOPLE ARE SMOKING CAMELS THAN EVER BEFORE!

Yes, experience *is* the best teacher in choosing a cigarette. Millions of smokers who have tried and compared different brands have found that Camels suit them best. As a result, more and more people are smoking Camels as the "choice of experience."

Try Camels. See if your own taste doesn't appreciate the rich, full flavor of Camels. See if your own throat doesn't welcome Camel's cool mildness.

Let your own experience tell you why more people are smoking Camels than ever before.

According to a Nationwide survey:

More Doctors Smoke CAMELS

than any other cigarette

When 113,597 doctors from coast to coast — in every field of medicine — were asked by three independent research organizations to name the cigarette they smoked, more doctors named Camel than any other brand!

INTERIM SESSION OF AMA

concluded from page 208

American Hospital Association will continue the study of this urgent problem.

There was discussion of a proposal to limit the number of interns for each hospital depending on its bed capacity to insure more equitable distribution of interns throughout the hospitals of the United Staes. This problem will be studied by a committee that will report at the annual meeting in June.

A proposal to limit the tenure of office of the members of the House of Delegates was defeated since it was very properly considered that tenure of office is a decision to be made by the State Societies who choose the Delegates to the national Association.

A resolution was approved which will call attention of Congress to the improper use of Federal Funds for propaganda in the Armed Forces.

The increased danger of the introduction of contagious diseases of all types into the United States by immigrants from so many parts of the world where public health service and medical care has been seriously disrupted by the war was stressed in one resolution introduced. This resolution recommended that thorough physical examinations including x-ray of the chest be done on all immigrants at the country of origin, or if this is not possible, at the port of entry in the United States. It was voted to call this to the attention of the U. S. Public Health Service, the Immigration Service and all others concerned.

Rather than presenting a routine report of the official business of the AMA, all of which has been thoroughly and accurately reported in the AMA Journal, I should like to pass on to the members of the Rhode Island Medical Society what was my most important reaction as a newcomer attending for the first time a session of the House of Delegates.

I had a firm conviction as a result of observation of the activities of the Delegates that the affairs of the American Medical Association are in good hands! It was enlightening and encouraging to see the serious and earnest manner in which the Delegates participated. Many are outstanding men who are leaders in American medicine and represent the best in American medicine. Many have obviously devoted much time and effort in performing the duties which have been assigned to them. The discussions even when there were marked differences of opinion, were conducted with courtesy and on a high plane.

So far as I am concerned, my experience at this meeting refutes completely the contention of those who would have us believe that the AMA is not democratic and that it does not truly represent the opinion and wishes of the majority of its members.

BOOK REVIEWS

SEXUAL BEHAVIOR IN THE HUMAN MALE, by Alfred C. Kinsey, Professor of Zoology, Indiana University; Wardell B. Pomeroy, Research Associate, Indiana University; Cylde E. Martin, Research Associate, Indiana University. *W. B. Saunders Company, Publishers, Philadelphia and London,* 1948

This remarkable book is the first of a series of books which are to appear as a result of a scientific research and study on problems in human sexuality. The survey was conducted by a staff of scientists at Indiana University and sponsored by the Committee for Research on Problems of Sex by the Medical Division of the Rockefeller Foundation.

Matters pertaining to sex have always held the interest and curiosity of mankind. The number of publications on sex will probably surpass any amount of literature written on any other subject. However, most of this material was not based on any factual findings, but reflected merely the writers' personal experiences, opinions and prejudices. In this manner a great amount of contradictory, untrustworthy, misrepresented and deceptive material has been accumulated. As a result our knowledge of factual human sexuality lacked scientific foundation.

Therefore, the research workers of this survey undertook to work out their problem as an objective scientific study. They have attempted to bring to our knowledge all the information pertaining to sexual activity and its variations as practiced by the human male of this country during our times. Twelve thousand case histories were obtained from men and women of all ages and of all walks of life. Most recent public poll findings methods were used and the findings were checked and rechecked by men especially trained in this field of work. This book is a result of nine years of such study and includes the summary of the findings and conclusions obtained by the leading workers of this survey.

This study is most complete and the wealth of material brought out in this book is astonishing. No matter how apparently insignificant or how important some of the subject matter appeared, as long as it concerned sex, the writers have tackled it with equal objective thoroughness. There is an enormous amount of factual data pertaining to medical, psychological, sociological, physiological and pathological aspects of human sex behavior.

Besides purely factual findings the authors of this book have done their own pioneering in explaining the reasons and aims of their study. This book is provocative enough in its factual findings, however, the authors have added interest by discussing their findings courageously as they affect some of the theories promulgated by various psychiatric schools of thought. Some of these ideas are supported by the findings of this survey. Others were, *e. g.,* Freud's theory on sublimation, found to be entirely without support.

The book is written in a clear and lucid language. There are many graphs, statistical tables and an exhaustive bibliography. Its place is indeed in the library of a physician, jurist, educator, psychologist, social worker and any person interested in human behavior. However, the use of this book should be restricted. It should not be accessible to adolescents and those lacking the necessary scientific background.

SIDNEY S. GOLDSTEIN, M.D.

TEXTBOOK OF CLINICAL NEUROLOGY, By *Israel S. Wechsler,* M.D., Publisher:—W. B. Saunders Company, $8.50, 1947.

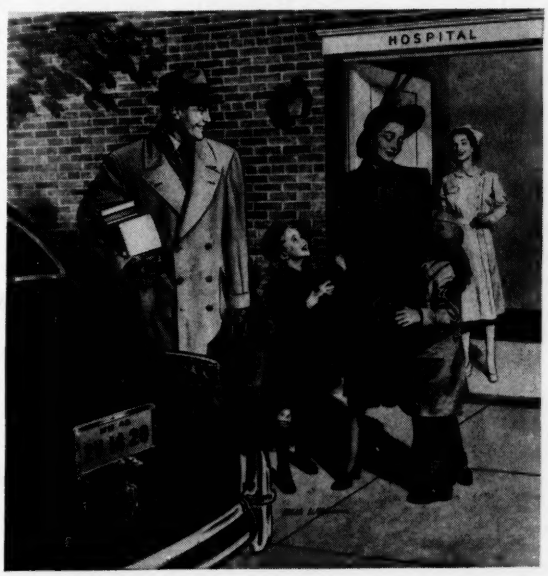
This edition has been extensively revised in order to include the recent additions to knowledge in the clinical field of neurology. However, the general plan follows the previous edition (5th). The noticeable progress in neurology made during the past four years is well described.

The one most noticeable omission in a neurological textbook which is described by the author as a "fairly complete repository of as much clinical neurology as can reasonably be gathered together between two covers", is the way the diseases of the nervous system of infancy and childhood are treated. Little or no effort has been made to bring together and to analyze all available information about these conditions. The neurological complications of diseases, not essentially neurological, are not given sufficient emphasis. Neither are the general aspects of these diseases.

continued on page 214

Some things you should know about operations

No. 210 in a series of messages from Parke, Davis & Co. on the importance of prompt and proper medical care.



OF ALL THE RECENT ADVANCES in medical science none have been more dramatic than those in surgery and the fields related to it. Take appendicitis, for instance.

Not very many years ago, having your appendix out might have meant a fairly long and uncomfortable hospital sojourn, followed by several tedious weeks of getting back your strength. And with it all you might have had good reason to fear such complications as peritonitis or pneumonia.

Nowadays, except for a few rare cases, the removal of an appendix is not considered a serious operation. And many operations which were considered of major seriousness as recently as 1930 are now often relatively simple.

Because of notable advances in training and surgical skill, many of the risks have been almost eliminated. Complications following operations are far less common. And most patients recover in a shorter time, and with less discomfort than formerly.

Such progress in surgery has been hastened by significant developments in four important fields.

1. Anesthesia. The administration of anesthetics has become a specialized science. New anesthetics have been developed—less toxic, less upsetting to respiration and heart action. With modern anesthesia the patient has a far easier time when undergoing surgery. Post-operative nausea and vomiting, which were previously almost taken for granted, are now much less frequent.

2. Infection-fighting drugs. Peritonitis, once feared as a frequent complication of abdominal surgery, today is uncommon. The use of such agents as the sulfa drugs and penicillin—to treat infection or to guard against it—has almost eliminated many of the infections which formerly constituted the greatest dangers in surgical procedures.

3. Early ambulation. Doctors have found that getting patients out of bed soon after operations not only speeds recovery, but also prevents many of the discomforts formerly suffered. Bowel and urinary functions are quickly restored. Gas pains are usually avoided. It is not unusual nowadays for a patient to be well enough to go home from the hospital in less than ten days after a major operation.

4. Body Nutrition. One of the problems in surgery has been that the condition which makes an operation necessary is usually one which has depleted the patient's nutritional reserves, and therefore lessens his ability to recover promptly from the operation itself.

In recent years, however, medical science has broadened its knowledge of body nutrition.

Today, it is possible to determine in what a patient's body is deficient—whether he needs whole blood, vitamins, salts, carbohydrates, protein.

Each of these elements can be replaced—making it far easier for the patient to go through an operation. Post-operatively, also, recovery is hastened by supplying the body's needs in easily assimilated form.

SEE YOUR DOCTOR. Give him your complete confidence at all times. If he advises an operation, follow his recommendation promptly. With modern surgery, with modern hospital care, you have little reason to be afraid.

Remember, too, that when surgery is indicated, a delay may be dangerous. Prompt action is likely to give you a quicker recovery—and an easier one!

BOOK REVIEWS

continued from page 212

The second point of doubtful value of this text is the inclusion of a section devoted to the neuroses. The enormous development of psychiatry in the past ten years makes it impossible to cover in any more than a wholly superficial manner, the various concepts of the emotional disorders and their manifold manifestations. To include material about the neuroses in a neurological text seems to serve no worthwhile purpose.

Of exceptional value, however, is the author's inclusion of a revised chapter on psychometric tests, now entitled "Psychological Diagnosis of personality disorders in organic brain syndromes." It is written in a manner which indicates the author's acceptance of a very recent trend among clinical neurologists today—to accept the idea that psychological methods enter more and more into neurological diagnosis.

As a textbook of neurology, the reviewer feels that it is at least on a par with the most recent publications in the same field. The disease enties are well described and the signs, symptoms, etiology, diagnosis, and treatment, described in terms already familiar to the specialist and easily understood by those having a basic grounding in neuroanatomy. A more detailed basic description of the electroencephalographic findings in the convulsive disorders and the use of this method in localizing cerebral lesions might well have been included.

THOMAS L. GREASON, M.D.

"Internal Medicine in General Practice" by Robert Pratt McCoombs, B.S., M.D., F.A.C.P. Second edition with 122 illustrations. 741 pages. W. B. Saunders Company, Philadelphia and London, 1947. Priced $8.00.

The substance of the previous edition has been completely revised and rearranged, and much new material has been added. The text consists of abstracts or concise condensations of present day knowledge of those diseases considered to be in the field of internal medicine. The author placed special emphasis on those diseases in which errors in diagnosis and therapy commonly occur. Specific information as to diagnostic methods and clinical tests have been incoporated in the text, as well as detailed recommendations for the treatment of each disorder. Sections on psychiatric disorders, diseases of the nervous sytem, and vascular disturbances of the extremities are included in addition to those sections dealing with the diseases and conditions usually considered to be in this field. At the time of the printing of the book, it was remarkably well up to date in therapeutics. The subject of chemotherapy with the sulfonamides, peni-

cillin and streptomycin forms an important section of the book. Other new therapeutic methods of proved value or of promise have been added. Among these are: lumbodorsal sympathectomy in selected cases of hypertension, the rice diet in hypertension and certain kidney diseases, high protein diets and protein hydrolysates in malnourished states, folic acid in macrocytic anemias and sprue, serum albumin in circulatory failure and nephrotic states, gamma globulins in the prophylaxis and treatment of measles and infectious hepatitis, chloroquine in malaria, para-amino-benzoic acid in rickettsial diseases, penicillin in syphilis and other infectious diseases, thiouracil and propylthiouracil in hyperthyroidism, estrogen therapy and castration in cancer of the prostate, benadryl and pyribenzamine in allergic disorders, cytochrome C in anoxic states, tridione in psychomotor disorders, heparin and dicumarol in vascular emergencies, and so on. The book has great value to the general practitioner, the student of medicine, and the specialist who wishes to quickly refresh his memory with specific knowledge and recommendations in the field of internal medicine.

HERBERT F. HAGER, M.D.

Pharmacology, Therapeutics and Prescription Writing. For Students and Practitioners. By Walter Arthur Bastedo, M.D. W. B. Saunders Co., Philadelphia, 1947. $8.50.

The fifth edition of this useful reference book has been completely rewritten. Doctor Bastedo felt that this was necessary because of the many new drugs and rapid advances in therapeutics.

Some of the new remedies he considers are rutin, BAL, radioactive iodine, thiouracil, folic acid and the coagulants. Method of action, therapeutics, administration, toxicology, contraindications and different preparations are listed for each drug.

HELEN DEJONG

The Years After 50 by Wingate M. Johnson, M.D., Professor of Clinical Medicine and Chief of Private Diagnostic Clinic, Bowman Gray School of Medicine of Wake Forest College. Whittlesey House, New York, 1947, $2.00

Dr. Johnson, also editor of his state journal, has recently been made a Trustee of the American Medical Association, and is greatly interested in the recognition and organization of the general practitioners of the country.

It seems safe to say that few men could have done a better job with this subject. Although the book is written evidently for consumption by the general public, it will make excellent reading for physicians; and although straight-forward and direct, he plays with no hobbies or personal hunches.

Every chapter is headed with quotations taken from little-known writings. Thus, he quotes Cicero, "A Good Old Rebel (Unreconstructed)", and Plato's "Republic." All through his writings there

continued on next page

PEDIATRIC MEETING

The Area I Meeting of the American Academy of Pediatrics will be held at the Hotel Statler, Buffalo, New York, April 29 to May 2, 1948.

Members of State Medical Societies are welcome to attend. The registration fee will be $5.00 for such non-members. This is in addition to the regular $5.00 registration fee for members making a total of $10.00 for non-members of the Academy. This registration fee includes a ticket to the banquet.

Registration may be made ahead of time by writing to Dr. C. G. Grulee, Secretary-Treasurer, American Academy of Pediatrics, 636 Church Street, Evanston, Illinois, enclosing a check for $10.00 or registration may be at the time of the meeting.

BOOK REVIEWS

concluded from preceding page

are frequent references to interesting people like William Osler, Samuel Johnson, and Amos Alonzo Stagg.

He devotes sometimes full chapters and sometimes portions to specific subjects that he thinks are peculiarly applicable to the aged, such as high and low blood pressure, diseases of the heart, dieting, and rheumatism. This book is easy to read. The reviewer feels that he has gotten a great deal of value out of it. We hope that it will be successful.

PETER PINEO CHASE, M.D.

THE BOOKS REVIEWED ABOVE ARE AVAILABLE TO MEMBERS OF THE SOCIETY AT THE MEDICAL LIBRARY.